Combatting the Crisis: Virtue Ethics as Foundation for a universal Medical Professionalism in the 21st Century

by

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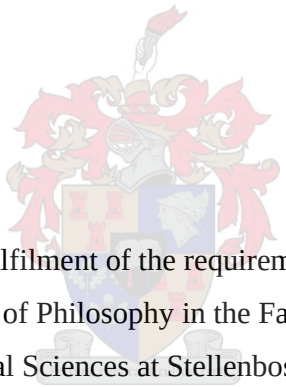

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Declaration

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Abstract

Medical professionalism is facing an existential crisis globally, one brought about by factors both internal and external to the profession. These include, amongst others, the increasing commercialisation, commodification and bureaucratisation of healthcare, the increasing division of medicine into specialities and sub-specialities vying amongst each other for a monopoly on certain skills and knowledge, a generational change in moral values and, ironically, the rise of the bioethics movement with an insistence that respect for autonomy be given primacy above all other considerations. This state of vulnerability is compounded by the modern medical profession floundering in a moral smorgasbord of principles, rules, duties, values and virtues to try and undergird medical professionalism. In this thesis I argue that medical professionalism is in such crisis precisely because grounding it in principlism and other broad-based moral theories such as Kantianism and Utilitarianism is untenable. Medicine is, and has always been, a moral enterprise, consisting of a rich millennia-old moral tradition unrestrained by cultural and national boundaries, and which is practiced within a moral community with specific role-generated moral values and responsibilities. I argue that a virtue-based approach, with the *telos* of medicine being found in the healing relationship between physician and patient, gives a coherent, comprehensive and normative account of medical professionalism, even in the 21st century.

Opsomming

Mediese professionalisme ondergaan huidiglik ‘n wereld-wye eksistensiele krisis, een wat aangebring is deur faktore beide intern en ekstern tot die professie. Hierdie faktore bestaan onder meer uit, die toename in die kommersialisering, kommodofisering en burokratisering van gesondheid, the toename in die verdeling van medisyne in spesialisasies en sub-spesialisasies wat tussen mekaar veg vir ‘n monopolie op sekere vaardighede en kennis, ‘n generasie verandering in morele waardes en, ironies, die onstaan van die bioetiese beweging wat aandring dat respek vir outonomiteit voorrang moet geniet bo enige ander oorweging. Hierdie kwesbare stand word vererger deur die mediese professie se poging om mediese professionalisme deur ‘n onsamehangende mengsel van prinsiepe, reels, pligte, waardes en deugdes te regverdig. In hierdie tesis, beredeneer ek dat mediese professionalisme homself in so krisis bevind juis omdat dit gegrond probeer word in prinsipalisme en ander bree-gebaseerde morele teoriee soos Kantianisme en Utilitarisme. Medisyne is, en was nog altyd, ‘n morele onderneming wat bestaan uit ‘n ryk, eeue-oue, morele tradisie oningeperk deur kulturele of nasionale grense, en wat beoefen word binne ‘n morele gemeenskap met sy eie rol-gegenereerde morele waardes en verantwoordelikhede. Ek beredeneer dat ‘n deugde-gebaseerde benadering, waar die *telos* van medisyne binne die genesings-verhouding tussen die geneesheer en die pasient gevind word, ‘n samehangende, ekstensiewe en normatiewe verklaring van mediese professionalisme bied, selfs in die 21ste eeu.

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Introduction

> Being a professional is rooted in our moral nature and in that which warrants and impels making public professions or avowals of devotion to a way of life. It is a matter not only of the mind and hand but also of the heart, not only of intellect and skill but also of character. For it is only as a member of a community and as a being willing and able to devote himself to others and to serve some higher good that a man makes a public confession of his way of life. To profess is an ethical act, and it makes the professional qua professional a moral being, who prospectively affirms also the moral nature of his activity (Kass 1983, 1307).

Medical Professionalism has become a popular topic in the last three decades with a wave of articles, books and conferences being dedicated to the topic. This is largely in response to the belief that medical professionalism is not only under immense threat but that it is in a state of rapid decline globally (Smith 2005, 439). The factors believed to be at the heart of this deprofessionalisation of medicine are, amongst others, the increasing commercialisation and commodification of medicine, the usurpation of physician decision-making authorities by insurance companies etcetera, the rise of consumerism leading to the replacement of physician beneficence with unrestrained patient autonomy and a generational change in prevailing work values where self-sacrifice and service to others has been supplanted by an emphasis on the self (remuneration and leading a balanced lifestyle involving ample leisure time) (Bernat 2012, 821). All these factors are thought to have contributed to the perceived weakening of the patient-physician relationship in contemporary medical practice.

As a result, there has been a notable effort to not only define medical professionalism but to also incorporate formal training in professionalism at undergraduate and postgraduate level. There is much debate around how to effectively teach professionalism and even greater disagreement on what moral framework should undergird professional ethics (or whether there is a need for such ethics in the first place). Despite lingering differences on what constitutes an adequate definition of medical professionalism, there is a growing conviction that a mere list of rules and regulations are not effective at ensuring professional conduct and deterring shortfalls in care (Arthur, et al. 2015, 4).

In an attempt to introduce a renewed sense of professionalism in the medical community, the American Board of Internal Medicine (ABIM) launched Project Professionalism in the early 1990's. They defined medical professionalism as: a commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge, a commitment to sustain the interests and welfare of patients and a commitment to be responsive to the health needs of society. Clarifying their definition, they identified professionalism as consisting of six key elements: altruism, accountability, excellence, duty, honour and integrity and respect for others (ABIM 1995, 5-6). This account was redefined, less than a decade later, to instead make use of the principles of bioethics in an attempt to define medical professionalism for the new millennium – an account that was readily accepted by most health regulatory bodies across the globe. These so-called "fundamental principles" of medical professionalism for the new millennium were presented as: the principle of primacy of patient welfare, the principle of patient autonomy and the principle of social justice (ABIM Foundation 2002, 116).

Historically, the practice of medicine has, essentially, always been a moral enterprise – its defining element being the relationship between the physician and patient (Marcum 2012, vii). For millennia, its practice has been governed by ethical codes and duties – from the code of Hammurabi, the oath of Hippocrates, the oath of Maimonides, to the treatises by John Gregory and Thomas Percival to name a few. Medicine, as a profession - one that is bound by ethical precepts - can thus be thought of as a moral community. As Edmund Pellegrino and David Thomasma point out, this is in large part due to the nature of illness itself – where the sick, vulnerable and anxious patient is forced to trust the physician within a relationship they would have preferred not to enter and one in which they are wrought, relatively, powerless (Pellegrino and Thomasma 1993, 35). This places a moral demand on the physician which does not ordinarily apply to the general populace. There are thus specific moral responsibilities which apply to those within the medical profession which are often at odds with the general ethos of the marketplace – which often emphasises self-interest over beneficence - that characterises much of Western, and increasingly Eastern, democracy.

Since the 1970's, born from the horrors of the Nazi atrocities and the ensuing Nuremberg trials, an increasing number of philosophers and academics have taken an interest in the moral dimension of the practice of medicine. Starting with the Belmont Report and Beauchamp and Childress' Principles of Biomedical Ethics, the field of Biomedical Ethics has grown exponentially, to the extent that no part of medical practice has not in some way been

influenced by its dominating moral principles – which are largely the product of moral philosophers. It cannot be denied that this inculcation of modern analytic philosophy has played an influential role in shaping contemporary medical practice. The two dominant normative moral theories for the last three centuries, namely Kantian Deontology and Utilitarianism have undoubtedly provided the foundation for Beauchamp and Childress' Principlism – especially the principles of respect for autonomy and justice. It is also, arguably, this reliance on these two dominant, broad-based, impartial theories that has led to the difficulty of not only justifying positive obligations of beneficence – for millennia the hallmark of the virtuous physician - but also circumscribing the role of the medical professional with its role-generated responsibilities.

It is this apparent inability of broad-based, universal, impartial theories to adequately capture the role of the medical professional, that has led to renewed interest in virtue theory as a basis for underlying a professional ethic. Since Elizabeth Anscombe's seminal article in the 1950's (Anscombe 1958), virtue ethics has slowly grown in influence and is now often regarded as being on an equal footing with the other two dominant normative moral theories within contemporary moral philosophy. For all its influence and history however, the development of virtue ethics is still in its relative infancy and a manifold of differing theories are considered part of virtue ethics – from Aristotelianism to Humean sentimentalism to Feminist theories.

In this thesis I develop a comprehensive normative virtue ethics approach to undergird the role of the medical professional and by extension medical professionalism.

In the first chapter I give an overview of medical professionalism, from its history to its contemporary formulation. I highlight the moral values that have been part and parcel of medical practice for millennia, stretching across cultural and national boundaries, and which can be conceptualised as forming the basis of a moral tradition. I then discuss the prevailing notion that modern medical professionalism is in crisis and the manifold reasons why this is believed to be the case.

In the second chapter I argue that the medical profession should be viewed as a moral community with distinct moral precepts which do not ordinarily apply to general society. I then show why broad-based, impartial moral theories such as Kantianism and Utilitarianism are not only unable to accommodate such a moral community, but that they fail decidedly to capture the value of moral roles such as those of friendship, and by extension the role of the medical professional. In addition, I also argue that both Kantianism and Utilitarianism are unable to

fully appreciate moral virtues such as benevolence, altruism and compassion: three moral values that have for millennia characterised the medical professional and his/her practice.

In the third chapter I develop a comprehensive normative virtue-based account for medical professionalism. I start by discussing the peculiarity of roles, a social phenomenon that pervades our moral lives. I then show how these roles are closely related to the character of those occupying specific roles. I follow that by outlining a virtue-based theory to medical professionalism. Drawing in particular on Aristotle and the concept of a *telos* I argue that, although a universal consensus on the *telos* for humankind cannot easily be agreed, it is possible to derive a *telos* for medicine. Drawing on the influential work of, amongst others, Alasdair Macintyre, Edmund Pellegrino and David Thomasma, and Justin Oakley and Dean Cocking, I construct first a *telos* for medicine – the good of medicine as an activity or practice. I then define virtue in terms of that practice followed by an explication of the virtues of medicine. I conclude by showing how an understanding of medicine possessing a moral tradition is not only essential to sustaining the virtues of medicine that constitute medical professionalism but that it also provides a virtue theory for medicine, through the virtue of *phronesis*, with its normative or action-guiding force.

Chapter 1: The Medical Profession: A Long History, a Modern Crisis

It began as little more than a faint whisper decades ago, a warning to heed the signs of the progressive decline of medicine as a profession. Yet no one appeared to listen at first, and why would they when such strident steps in moral progress had been made in the aftermath of the Second World War and the atrocities committed by Nazi Germany. How could it be true that the medical profession was spiralling towards an existential crisis when such ground-breaking work was being conducted, not only in the field of biomedical science, but also in the field of medical ethics with such landmark publications as the Belmont Report and Beauchamp and Childress' Principles of Biomedical Ethics. Yet, as the millennia old tradition of the profession, including its oaths, appeared to be becoming increasingly vapid, the cries of alarm became ever more vociferous. Under the weight of a market-place ethos and an ideology espousing radical individual autonomy above all other considerations, the medical profession was under increasing scrutiny to conform – some like Robert Veatch proclaim the idea of a profession to be wholly antithetical to contemporary morality, of universal moral standards that apply to all equally, and is thus deserving of being discarded to the dustbin of history (Veatch 2009, 34). This bleak outlook sparked a reaction from within the medical community in the early to mid-90's with, amongst others, the ABIM's Project Professionalism - a bold initiative that aimed to reinvigorate the dying embers of medical professionalism. A call to continue to uphold those moral values which for millennia had undergirded the practice of medicine as a morally distinct entity.

In the following chapter I will proceed to discuss the historical roots of medicine as a profession and what the term professionalism has historically entailed leading up to the myriad of modern conceptualisations of medical professionalism. I will then discuss some of the reasons for it being in crises.

The History of the Medical Profession and Professionalism

Derived originally from the Latin term "*profiteri*", meaning to profess publicly, the modern broad understanding of the term profession denotes an occupation which one professes publicly to be skilled in and which usually requires prolonged and intensive training. Despite this modern usage, which invariably could describe almost any occupation, the ancient understanding of a profession did not merely mean that one had the requisite skill to do the job.

In Middle-English the term profession, in Latin *professio*, came specifically to be associated with the vows that one made when one entered a religious order. As Tom Koch states, professions were understood to be those bodies of people who not only had a defining skill set and/or knowledge but also a declared moral perspective governing its application (Koch 2019, 221). It is for this reason that the term profession was traditionally used to refer to those who practiced medicine, law or the clergy. For James Bernat, the Latin term *professio* – meaning to speak forth a public oath of fealty - captures the essence of what it means to be a professional: one that pledges him/herself to a service ideology in which concern for the welfare of, and devotion to those whom the professional serves, is granted primacy above the professionals personal or proprietary interests (Bernat 2012, 820). The concept of a profession and a professional in this sense goes back millennia.

The *Code of Hammurabi* (1754 BCE) can rightfully be said to be the first recorded example of the setting down of laws to specifically govern the practice of medicine.

> If a physician makes a large incision with the operating knife, and kill him, or open a tumour with the operating knife, and cut out the eye, his hands shall be cut off. (Halwani and Takrouri 2006, Law 218)

> If a barber, without the knowledge of his master, cut the sign of a slave on a slave not to be sold, the hands of this barber shall be cut off. (Halwani and Takrouri 2006, Law 226)

Although the code of Hammurabi thus contained the first known conception of laws governing the practice of medicine, the traces of medicine as a profession outlined by Koch and Bernat above can first be seen, at least in the West, with the medicine practiced by the physician Hippocrates of Cos (460 – 370 BCE). Not only was the Hippocratic Canon the first systematic ordering of medical knowledge, it also included a covenant espousing the moral ideals of medical practice – most notably the virtues of beneficence and nonmaleficence which are still in use today as part of the four principles of bioethics (Beauchamp and Childress 2013). Central to the practice of Hippocratic physicians – important to distinguish since it is not true that all Greek physicians subscribed to the Hippocratic tradition at the time (Wynia 2008, 566) – was the swearing of the eponymous oath at the beginning of their studies and to which they, as later practitioners, were expected to bear complete allegiance. Although the Oath begins with an invocation to the gods the Oath should not be seen as a priestly document but as a pledge of trust (Nuland 1995, 27). A pledge of trust that professed to care primarily for the individual

patient and through him/her for the society at large, irrespective of ability to pay or the patient's social standing. In Greek society there was no clear distinction between the individual and the community, or *polis*, and thus caring for the individual would, arguably, have been understood as forming part of the greater communal good (Koch 2019, 222). Although the Hippocratic physicians were undoubtedly paid for their services there is nothing within the Oath or the Corpus to suggest that remuneration was part of the motivating drive in the practice of the art of medicine. Hippocratic medicine appeared to be morally grounded in caring for the patient first, and through that for the community at large and not as an entrepreneurial activity. The result was thus a moral imperative to care for the sick irrespective of any other considerations.

This concept of a profession being a public oath of trust, a promise to be competent – i.e. devoted to the art - and to serve the sick irrespective of all other considerations including self-interest, was carried forth in the ethic of the little-known Roman physician Scribonius Largus. It is here that, for the first time, the practice of medicine is described as being a profession – of which Hippocrates is said to be the founder (Edelstein 1967, 339). In his manuscript on pharmacology entitled *Compositiones* (44-46AD), Scribonius expounds on a medical ethic which contains, surprising for his time and nationality, distinctly humanistic elements (see the translation by Pellegrino and Pellegrino (Pellegrino and Pellegrino 1988, 25-29) from the Teubner Scribonius by Sergio Sconocchia (Largus and Sconocchia 1983). Scribonius' ethic, inspired by both Hippocrates and Greek Stoicism, emphasises the grounding of the physician's moral obligations in the special nature of his role in society, the virtues intrinsic to that role such as compassion and benevolence, and its status as a moral imperative (Pellegrino and Pellegrino 1988, 23). Scribonius describes the practice of medicine as a calling, one that eschews self-interest and is instead driven by a love for mankind and a love for the art (*philanthropia and philotechnia).* For Scribonius, the taking of an oath is a *sine qua non* of the medical profession and that anyone who dares to violate the moral obligations that such an oath imposes should be hated by all the gods and men alike (Hamilton 1986). Scribonius is also at pains to emphasise that the moral obligations that bind the physician are role specific. He contrasts these obligations of beneficence and non-maleficence for all who are sick, irrespective of wealth, character or whether they are an ally or an enemy, with those that bind a soldier or the common citizen – a striking remark for a Roman citizen to make. For Scribonius, a soldier or citizen (even if the physician himself should be forced into that role) is under no such obligations.

> All gods and men should hate the doctor whose heart lacks compassion and the spirit of human kindness. These very qualities, after all, preclude the physician, bound by the sacred oath of medicine, from giving a harmful drug even to an enemy - yet the physician will attack that same enemy, when occasion demands, in his role as a soldier and good citizen. Medicine, however, does not measure a man's worth according to his wealth or character, but freely offers its help to all who seek it, and never threatens to harm anyone (Pellegrino and Pellegrino 1988, 26).

This idea, that morality and character is tied up in our roles in society, is ancient, as can be seen in Macintyre's explication of the virtues in Heroic Society (Macintyre 2007, 141-151). As Tim Dare and Christine Swanton elucidate, even in contemporary society our moral lives would be wholly unrecognisable without roles (Dare and Swanton 2020, 1). It is arguably the greatest failure of Western analytic philosophy, with its commitment to universalizability, impartiality, the individual in lieu of the community and the idea that ethics should be theorised and practiced from the standpoint of humans as humans and not humans as fathers, mothers, friends, lawyers or doctors etcetera, that the concept of role-obligations has been largely ignored. This will be discussed in greater detail in chapter 3 of this thesis.

It was not only in the Ancient West however, that a professional ethic, comprising a covenantal pledge to upholding humanistic values and a devotion to the art, was evident in the practicing of medicine. In Ancient Egypt, millennia before the arrival of either the code of Hammurabi or the Oath of Hippocrates, the physician Imhotep had already established the practice of medicine as an art with a comprehensive body of medical knowledge that was widely disseminated amongst Ancient Egyptian practitioners. Imhotep was held in such high regard in Ancient Egypt that he was deified. "Turn thy face towards me, my Lord Imhotep, son of Ptah. It is thou who dost work miracles and who are beneficent in all thy deeds…" were the words of supplication used to address him (Rogers 1972, 39). There is good evidence which suggests that prominent ancient Greeks, including Pythagoras – who later influenced Hippocrates - studied medicine in Egypt. There have also been strong suggestions that the Hippocratic Oath was in fact copied, or at least inspired, by the teachings of this ancient African physician (Bailey 2005, 117) (Pickett 1992) (Newsome 1979, 192).

In the Far East, ancient physicians espoused a surprisingly similar professional ethic as their Western counterparts including the pledging of oaths or covenants to govern their profession. This is perhaps surprising since the moral philosophies of East and West – at least since the enlightenment - have been deemed to be in a state of irreconcilable conflict. The ethics undergirding the practice of the ancient Chinese physician Sun Simiao (581-682 CE) however, espouses similar moral values as those of other ancient physicians in the West (Zwitter 2018, 10). In his manuscript entitled: *On the absolute sincerity of great physicians*, often referred to as the Chinese Hippocratic Oath, Sun Simiao emphasises that compassion (*tz'u*) and humaneness (*jen*) are the two fundamental values that undergird medical practice (Tsai 1999, 315).

> He should not give way to wishes and desires but should develop first of all an attitude of compassion. He must vow to rescue the sufferings of all sentient beings (Unschuld 1979).

Similar to the professional ethic espoused by ancient physicians in the West, Sun Simiao entreats physicians to treat all patients the same irrespective of class, wealth or character, and to defer from motivations of self-interest in the practice of their art.

> If someone comes for help, he must not ask if the patient is noble or common, rich or poor, old or young, beautiful or ugly. Enemies, relatives, good friends, Chinese or barbarians, foolish and wise all are the same. He should think of them as his closest relatives. He should not be overly circumspect and worry about omens or his own life. He should look on others' sufferings as his own and be deeply concerned (Unschuld 1979).

As the West entered the dark ages with the fall of the Roman Empire, the Islamic world experienced their golden age, characterised by profound advances in the fields of astronomy, mathematics, philosophy and medicine to name a few. Influenced by the writings of the ancient philosophers and physicians of Greece and Rome, which were all translated into Arabic, physicians such as Al-Ruhawi and Al-Razi (Rhazes) wrote extensively on medical ethics. Known as the Galen of the Arabs, the physician-philosopher Al-Razi (865-925 CE) was a distinguished scholar who published extensively in a wide variety of fields, most notably medicine (Chamsi-Pasha and Albar 2013, 674). One of his most famous works, entitled *Akhlaq al-Tabib* (translated: Medical Ethics), explicates the duties and responsibilities that a physician should adhere to in the practice of his art (all physicians were men). For Al-Razi, the duties of

the physician (understood in the deontological sense since all moral laws are given by God) include first the duty to treat patients with utmost kindness. According to Al-Razi, physicians must never be rude or aggressive, but always soft-spoken, compassionate and modest (Karaman 2011, 83). Similar to the Hippocratic Oath, Al-Razi writes that physicians are duty-bound to keep information about their patients confidential and emphasises that physicians must always treat their patients equally irrespective of wealth (Karaman 2011, 83).

The *Adab al-Tabib* (translated: Practical Ethics of the Physician), written by the 9th century physician Al-Ruhawi is another highly influential Islamic work and is often considered the earliest Islamic writings on medical ethics. A contemporary of the better-known Al-Razi, Al-Ruhawi summarises the duty of the physician toward his patients as follows:

> The method of justice of the physician and its beginning is that it is necessary to be good, training one's self, and taking care of it by employing good morals and actions with sympathy, mercy, gentleness, chastity, courage, generosity, being just, retaining a secret, and anything similar as the virtues of the soul and its proper breeding with work, acquiring the art, studying its books and their meanings so as all to practice them and to bestow their benefits on people without distinguishing them as to friend or foe, in agreement or disagreement (Levey 1967, 13).

Thus, as should be evident, the ancient physicians, irrespective of era, culture or geographical location share a striking commonality - a deep-set devotion (fealty) toward upholding the moral values that underlie the art of medicine. These are the emphasis on the character of the physician, the upholding of humanistic values such as compassion and benevolence, a disregard for the self (altruism), the insistence that the physician should be competent and a disdain for those who bring the profession into disrepute.

During the enlightenment period in the West these values underlying a professional (role-generated) ethic in the practice of medicine remained largely intact – despite remarkable philosophical, political and economic changes to society. The two most influential thinkers on medical ethics, particularly professional ethics, were undoubtedly John Gregory and Thomas Percival. Many philosophers credit these two as the true architects of modern professionalism with their insistence that the profession is a public trust – in addition to the emphasis on

competence and virtue espoused by the ancient physicians – since the profession has both a social obligation to their individual patients as well as the broader community and science in general (McCullough 2004, 13). As I have stated, this is to some extent absent in the ethics espoused by the ancient physicians since their conception of the individual, community and social roles was wholly different to the liberal individualism of the enlightened West at the time of Gregory and Percival.

John Gregory (1724-1773) was a Scottish Physician who is credited by some with inventing the concept of medicine as a fiduciary profession – where individuals and institutions act primarily to protect and promote the interests of patients whilst relegating self-interest to a secondary position (McCullough 1998, 4) (Chervenak and McCullough 2001, 876). Influenced by the moral philosophy of his fellow Scot David Hume, the virtue of sympathy comes to be viewed as a moral imperative for the physician. In *Observations on the Duties and Offices of a Physician and on the Method of Prosecuting Enquiries in Philosophy*, Gregory writes:

> I come now to mention those moral qualities peculiarly required in the character of a physician. The most obvious of these is humanity; that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which of consequence incites us in the most powerful manner to relieve them. Sympathy produces an anxious attention to a thousand little circumstances that may tend to relieve the patient; an attention which money can never purchase: hence the inexpressible advantages of having a friend for a physician. Sympathy naturally engages the affection and confidence of a patient, which, in many cases, is of the utmost consequence to his recovery. If the physician possesses softness and gentleness of manners, a compassionate heart, and what Shakespeare so emphatically calls "the milk of human kindness," a patient feels his approach like that of a guardian angel ministering to his relief; while every visit of a physician who is unfeeling, harsh or brutal in his manners, makes his heart sink within him, as at the presence of one, who comes to pronounce his sentence of death. Men of the most compassionate tempers, by being daily conversant with scenes of distress, acquire in process of time that composure and firmness of mind so necessary in the practice of physick (Gregory 1770, 18-19).

In his lecture series on the *Duties and Qualifications of a Physician*, Gregory formulates his conception of professionalism on three pillars: competence (he terms it genius), humanism and,

what McCullough calls, a public trust (McCullough 2004, 13). By the latter, Gregory meant that it was morally incumbent on those within the profession to impart their knowledge, not only amongst themselves, but also with the public at large in order to improve the lives of their broader community and to advance science in general. Gregory writes:

> I have thus endeavoured to show that, by laying medicine open, and encouraging men of science and abilities, who do not belong to the profession, to study it, the interests of humanity would be promoted, the science would be advanced, its dignity more effectually supported, and success more certainly secured to every individual, in proportion to his real merit (Gregory 1772, 236)

Despite John Gregory's remarkable contribution to medical ethics – many of his ideas were progressive for his time as Laurence McCullough illustrates poignantly (McCullough 1998, 1-2) – it is the English Physician Thomas Percival (1740-1804) who would, arguably, prove to have the most marked influence on modern professional ethics; culminating in the first publication of a standardised national code of medical ethics in 1847 by the American Medical Association (Wynia 2008, 567). In his most famous publication, *Medical Ethics*, Thomas Percival endorses Gregory's idea – he credits him directly - of medicine being a fiduciary profession consisting of the duty of physicians to be competent, the duty to uphold humanistic values and to promote medicine as a public trust - instead of a trade guild which is what the practice of medicine had devolved into at the time (McCullough 2004, 13). As C. Ronald Mackenzie remarks, there is in the writings of Gregory and Percival a noteworthy emphasis on the patient instead of on the physician (Mackenzie 2007, 222). Percival opens his manuscript with the following words:

> Hospital physicians and surgeons should minister to the sick, with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge depend on their skill, attention, and fidelity. They should study, also, in their deportment, so to unite tenderness with steadiness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence (Percival 1803, 9).

Despite this shift towards the patient rather than merely focussing on the physician – I would argue that this could be a consequence of the shift in moral thought that had and was happening at the time (the Enlightenment emphasis on the individual and liberty in lieu of social roles which constrain freedom (Takala 2007, 227)) – Percival still holds surprisingly consistently to

the ethics that had undergirded the practice of medicine of the ancients. The emphasis on medicine being an art, instead of merely a trade, the importance of the physician being a person of moral standing and the rejection of self-interest in medicine's practice is still very evident in his writings.

> But in the consideration of fees, let it ever be remembered, that though mean ones from the affluent are both unjust and degrading, yet the characteristical beneficence of the profession is inconsistent with sordid views, and avaricious rapacity. To a young physician, it is of great importance to have clear and definite ideas of the ends of his profession; of the means for their attainment; and of the comparative value and dignity of each. Wealth, rank, and independence, with all the benefits resulting from them, are the primary ends which he holds in view; and they are interesting, wise, and laudable. But knowledge, benevolence, and active virtue, the means to be adopted in their acquisition, are of still higher estimation. And he has the privilege and felicity of practising an art, even more intrinsically excellent in its mediate than in its ultimate objects. The former, therefore, have a claim to uniform pre-eminence (Percival 1803, 40-41).

The writings of Thomas Percival would prove so influential that they would serve as the inspiration for the first nationally standardised code of medical ethics in 1847 by the American Medical Association. Quoted almost verbatim from Percival's work, the AMA's code of medical ethics was divided into three distinct duties that physicians were expected to adhere to (AMA 1847). First, the physicians' duties toward their patients, secondly, the physicians' duties toward each other and their profession, and thirdly, the professions' duties toward the public. It is this institutionalisation of a code of professional ethics that undergirds the practice of medicine, including standardisation of education and licencing of physicians, that gave birth to the modern concept of medical professionalism.

During the subsequent decades, several small changes would follow to the AMA's code of medical ethics and many other medical organisations and regulatory bodies across the world would follow suit with their own codes. The Health Professions Council of South Africa revised their own core ethical values and standards for good medical practice in 2016 consisting of thirteen distinct concepts – Respect for persons; Non-maleficence; Beneficence; Human rights; Autonomy; Integrity; Truthfulness; Confidentiality; Compassion; Tolerance; Justice; Professional competence and self-improvement; Community (HPCSA 2016, 2-3).

With the crises of professionalism deepening around the 1970's – to be discussed - the American Board of Internal Medicine (ABIM) established their Project Professionalism in the early 1990's to enhance professionalism and promote the integrity of internal medicine and the broader medical profession in response to what they perceived as an eroding of professional standards (ABIM 1995). The ABIM defined Professionalism as:

> A commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge. A commitment to sustain the interests and welfare of patients. A commitment to be responsive to the health needs of society (ABIM 1995, 5)

They define these elements further as altruism, accountability, excellence, duty, honour and integrity and respect for others. It is noteworthy however, how close the three pillars of professionalism espoused by John Gregory and Thomas Percival - competence, humanistic values and the profession as a public trust - is encapsulated in the three commitments of the ABIM's definition of professionalism. There is no mention of either Gregory or Percival, or any other ancient physicians in the ABIM's report but it would be absurd to presume that they formulated their definition *de novo* – it is merely an unacknowledged repetition of a traditional ethic stretching back at least to Gregory and, I argue, thousands of years further.

Although the ABIM's professional ethic closely resembles that of Gregory and Percival, and by extension that of the ancients, the Charter on Medical Professionalism in the New Millennium published jointly by the ABIM Foundation, ACP-ASIM Foundation and the European Federation of Internal Medicine shows a remarkable shift in moral emphasis – published less than a decade after the ABIM's Project Professionalism. Despite acknowledging the history of medicine stretching back to Hippocrates, the traditional values and ideals of medicine and the role of the physician as healer – they deftly ignore the contributions of Gregory and Percival - it is suddenly the principles of bioethics (autonomy, beneficence, non-maleficence and justice) that are regarded as the foundational principles of medical professionalism (ABIM Foundation 2002). This is hardly surprising given the almost religious devotion to principlism, first espoused by Beauchamp and Childress in the 1970's (Beauchamp and Childress 2013), in the field of bioethics and broad-based moral theories in analytic philosophy. I will argue later, predominantly in chapter two, that these justifications fail and that this is one of the causal factors which underlies the current crisis in medical professionalism.

In conclusion, I have elucidated how both ancient and more modern physicians from across the globe, spanning not only millennia but also vastly differing cultures, religions and moral philosophies agree with surprising uniformity what values, virtues and behaviours are expected from medical professionals – where the term professional refers to a member of a profession and professionalism the conduct, aims and qualities of such a member . As Fabrice Jotterand alludes, this commonality might be because what these physicians, both ancient and more modern, espouse are values internal to medicine - a medical-moral philosophy that is specific to the medical profession irrespective of the societies in which these writers found themselves (Jotterand 2005, 108). The goal of this thesis is to argue that not only is this true, but that it is best undergirded by virtue theory – the moral theory that not only dominated the Western world until the enlightenment – after which it was largely discarded and is only recently re-emerging – but that also has strong roots in Chinese Confucianism, Japanese Bushido-ism and African Ubuntu Ethics amongst others.

The Crisis of Modern Medical Professionalism

I have, to a large extent, defined the three terms: profession, professional and professionalism, in the previous chapter but I feel it necessary to elaborate. There appears in modern times an almost reflexive urge to redefine terms whose meanings have been clear to all people for eons. The medical profession, at least since Scribonius Largus first penned the term, has always referred to the collective of people who professed publicly that they practiced medicine. This professing, as Sethuraman states, has always been done in two ways. The first is the oath taken by all medical graduates, stating an absolute commitment to a code of moral precepts and the second is the physician-patient relationship in which the physician implicitly professes to possess the requisite knowledge and skill to act in the patients best-interest (Sethuraman 2006, 1). As stated before, this emphasis on humanistic values and competence – or devotion to the art - were ingrained in the philosophy of medicine of the ancient physicians. It was only during the enlightenment period in the West that Gregory and later Percival discussed the profession as having a fiduciary obligation, not only to the individual patient but also toward society at large. This is not surprising given the time-period in which these physician-ethicists lived and their contribution to the modern understanding of the medical profession, and a medical professional ethic, cannot be understated. Despite McCullough's insistence that these two are the true progenitors of medical professionalism it would be remiss to ignore the medical

tradition which stretches back thousands of years. It would be absurd to suggest that the Hippocratic physicians did not see the practice of their art as being a service to the community or *polis*. In Ancient Greece there was no conceptual understanding of the individual outside of his/her community or his/her role in society – see Macintyre (Macintyre 2007, 142) - and the same applies to the Far East and Africa. It is why modern Western concepts such as human-rights and individual autonomy would have been wholly foreign to these cultures. This understanding of the self only in relation to the community (self-in-community) is still true of most Far Eastern and African societies today (Ihara 2004, 26)(Mkhize 2014, 46).

My definition of medical professionalism is focussed largely on the individual practitioner's character and his/her conduct or responsibilities as a member of the profession – where the profession is regarded as a public trust and thus enjoys considerable autonomy to self-regulate. In the broadest sense, as Stoddard et al succinctly state, professionalism is defined along three key elements: expert knowledge, self-regulation or autonomy and an obligation to subordinate self-interest to the needs of the client as well as other humanistic values (Stoddard, et al. 2001, 676). Until recently, this has largely been the focus of discussion within the medical professionalism literature. Contemporary views, however, are moving away from the physicians' motives and behaviours toward a more macro-perspective involving how systems and structures (social, political, environmental) affect individuals and how organisations can embody professional values (Hafferty and Levinson 2008, 600) – this may be because of the failure to justify professionalism using broad-based normative moral theories (to be discussed later). Creuss and Creuss believe that, whilst the traditional definition of professionalism would have sufficed previously, modern society is undergoing such rapid change that in order to maintain the relationship – between society and the profession - the profession and thus professionalism must continually evolve (Creuss and Creuss 1997, 943). To this end, Creuss and Creuss identify two wholly distinct ethical entities that comprise those who form part of the medical profession: the physician-healer and the physician-professional – and physicians are expected to simultaneously occupy both roles. Despite Creuss and Creuss' advocacy in favour of medical professionalism, it is precisely this sort of unnecessary and confusing division that causes such bewilderment to reign – which role has primacy if they should conflict or is this another case of weighing up options and everyone then deciding for themselves on a case by case basis? The inability to formulate a proper – read acceptable to a morally pluralistic society - definition of medical professionalism is one of the principle reasons why professionalism is in crisis.

In order to discuss the crisis medical professionalism finds itself in further, it is necessary to distinguish between internal and external causes. I have deliberately divided them as such, although they are interlinked. As far as external causes are concerned it is not to say that the profession is blameless – since by its own failings it allowed the external causes to plunge medical professionalism into crisis in the first place. I am merely conveying that the external causes did not originate necessarily from within the profession itself.

In terms of internal forces, there are four major weaknesses that have had a crippling effect on professionalism. The first is the increased specialisation in medicine as a result of an explosion in medical technology and scientific knowledge in the last century, most notably the last fifty years. Although there are some advantages to this specialisation – such as providing more in-depth care in specific cases - a house divided cannot stand. This division of the medical profession into countless subdivisions (and further subdivisions within subdivisions) has inadvertently led, to some degree, to the creation of the tribal mentality of us and them – instead of a unified collective – and has, in some countries, led to each speciality claiming a professional monopoly on certain medical knowledge and skills (Detsky, Gauthier and Fuchs 2012, 463). Not only has this weakened the profession to outside influences such as managed-care, insurance companies and other for-profit groups – who subsequently decide which professional can treat what and how - but it has also increased the risk for unprofessional behaviour and the loss of a holistic approach to patient care in which the patient is viewed as a biological, psychological and social being. As Plochg et al note, with the increase in chronic diseases and patients presenting with overlapping diseases (multi-morbidity) there is a need for greater coordination between disciplines that is often lacking as a result of the competitive (market-orientated) environment that has been created (both internally and through market-forces) (Plochg, Klazinga and Starfield 2009) and the approach which justifies the specialist only being concerned with his own expert domain. This has also led, inadvertently, to a spiralling in the cost of healthcare and the erosion of trust in the profession by the public at large – the perception that medical professionals are merely interested in the accumulation of wealth is increasing (Girgis 2017).

The second internal weakness that has led to the professionalism crisis has been the poor formal educative efforts to teach medical professionalism. Historically, at least since the time of William Osler, professionalism has been taught through the use of role-models (Wright, et al. 1998, 1986). Termed “the hidden curriculum” by contemporary writers, it was believed that there was no need to teach professionalism formally since it was already an inherent part of

medical training – experiential learning and the imitation of role-model physicians - which had been the mainstay for centuries. As Creuss and Creuss argue however, there is a need to incorporate formal training in professionalism as what had been done in the past was/is often selective and disorganised (Creuss and Creuss 2012, 260). With the realisation that professionalism is in crisis, a swathe of books and journal articles have been dedicated to the topic of professionalism education. The two lingering problems – defining professionalism (and its moral justification) and finding a suitable mechanism to evaluate professionalism – remain a stumbling block, however, that so far has not been successfully overcome.

The third internal weakness that has led to the modern crisis in professionalism has been the poor and irregular self-regulation of the profession (Creuss and Creuss 2012, 259). The professional autonomy that has been entrusted by the public onto the medical profession has been severely eroded in recent years by the litany of media reports detailing the shocking behaviour of both individual medical professionals and health care institutions (Stern 2006, 3). The well-known case of the death of Steve Biko in South Africa during Apartheid and the lack of the profession to hold the physicians involved to account is a particularly poignant example of this erosion of trust (van Niekerk and Benatar, The Social Functions of Bioethics in South Africa 2011, 137).

The fourth internal weakness that has led to the modern professionalism crisis has been the inability to articulate a normative moral theory to underpin professionalism. As Jack Coulehan expresses pointedly, the community of medicine suffers from an impoverished moral imagination (Coulehan 2006, 103). The thrust of this thesis is to argue for the coherence of a virtue-based approach to medical professionalism in lieu of broad-based theories such as Kantian Deontology, Utilitarianism and Principlism. I will not go into further detail here as my argument will be expanded upon as this thesis unfolds; suffice it to say that, since I argue, contemporary definitions of medical professionalism have been grounded on such a weak and incoherent moral edifice, it cannot hope to weather the numerous factors which have placed it in such predicament.

With regards to external causes, there are a manifold of factors that have caused the crisis in medical professionalism and it is beyond the scope of this thesis to highlight them all. Most modern literature on the topic of professionalism agrees that commercialisation and the ethos of the market-place, which has led to the commodification of medicine, is one of the greatest, if not the greatest, reason for the current crisis in medical professionalism (Brody and Doukas

2014, 982) (Smith 2005, 339) (Bernat 2012, 821) (Koch 2019, 6). It is likely, as Koch states, that there has always been a tension between the entrepreneurial aspirations of individual physicians and the altruistic ideals which has traditionally characterised professional ethics since at least the time of Hippocrates (Koch 2019, 5). Yet, as William Osler so poignantly wrote: "The practice of medicine is not a business and can never be one, the education of the heart — the moral side of the man — must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals in corn and coal. The human heart by which we live must control our professional relations (Osler 1903, 276)."

The contemporary practice of medicine around the globe, including South Africa, could not be further from Osler's understanding. Healthcare has become a commodity – a marketable property - where physicians are seen as "service-providers" and the patients as "consumers" (Dougherty 1990, 275). The physician-patient relationship has been redefined as one of seller-buyer (Williams 2009, 49). This business, or entrepreneurial, ethos has invaded medical practice to the degree that monetary gain has in some sense wholly usurped the altruistic rewards of medicine (Churchill 2007, 413). At a recent continuing professional development seminar I attended, entitled: Business and Medicolegal Risk, the speaker asserted quite adamantly that it should be considered unethical for a medical professional not to make money in his/her practice. Sponsored by a host of for-profit healthcare companies all vying like wolves for the attendees' attention and future business, the nods of agreement from fellow professionals, especially those working in the private sector, emphasised starkly how detached medicine has become from its traditional professional identity of altruistic and humanistic service. In an age where the market-place ethos dominates and money has been afforded a new moral quality, it is understandable that many health professionals – similar to the rest of modern society - now define themselves by their wealth in lieu of their professional identity (Churchill 2007, 410) - as entrepreneurs first and professionals second. This shift has led to an acceleration in the deprofessionalisation of medicine and a general decrease in public trust since patients can no longer be certain in whose interest the physician is acting (Bernat 2012, 822). It is unsurprising then that many leading scholars have concluded that commercialisation is incompatible with medical professionalism (Angell 2000) (Liesengang 2008) (Pellegrino 1990). As Albert Jonson eloquently states: "…the central paradox that pervades medicine arises from the incessant conflict between the two most basic principles of morality: self-interest and altruism, and in no institution is this paradox more central than in contemporary medicine (Jonson 1983, 1532)."

It is not only the rampant and poorly regulated commercialisation of medicine that is eroding professionalism, however, but also the consumerism movement that is part and parcel of it. As JR Williams notes, there is a tendency to view medicine as a consumable product similar to all other consumable goods (Williams 2009, 49). Ironically, the rise of the field of bioethics, which gained considerable traction in the early 1970's, has been cited as one of the reasons for fuelling the rampant consumerism rife in medicine today. The perceived triumph of individual autonomy over medical paternalism – according to Jonathon Moreno the result of distinct events such as the uncovering of the Tuskegee Syphilis trials, the case of the vegetative Karen Ann Quinlan and the pro-choice judgement in *Roe v Wade* in the US (Moreno 2007, 416-417) – had the unintended effect of denigrating medical professionalism as well. Not only did this emphasis on individual autonomy trump all other moral considerations – the principle of respect for autonomy is often considered to be first-among-equals (Gillon 2003) despite Beauchamp and Childress insisting that it is a misreading of their work – but it also led to a loss of professionals' sense of civic responsibility and the idea of medicine as a public trust. As Matthew Wynia points out begrudgingly, medical ethics' overzealous insistence on the moral supremacy of individual autonomy – more often than not pushing the agenda to the absolute extreme in the case of Robert Veatch (Veatch 2009) – led to physicians being forced to consider only the welfare of their patients, irrespective of all other considerations (Wynia 2008, 573). Couple this with the rise of consumerism, the loss of professional autonomy and the burgeoning culture of litigation to resolve disputes and it could be argued that the physician's sole role in contemporary medicine is not even to focus on the welfare of patients but to acquiesce to the autonomous demands of individual clients. In such an environment it is little wonder that traditional medical professionalism is in crisis and that the business ethos of self-interest now thrives, whether through individual practitioners or large for-profit health organisations.

This mindset of self-interest above considerations of altruistic care for the individual patient and the community, which for centuries has been the cornerstone of medical professionalism, has been compounded (if it is not part of the cause) by a generational shift in how medical students view their future in the profession. Increasingly, there has been a reluctance by the newer generation of medical students to accept the role of 'doctor' and the moral responsibilities such a role entails – often characterised by long hours, demanding work schedules and self-sacrifice (Smith 2005, 440). Possible reasons for this have been the generational emphasis on the importance of a controllable, balanced lifestyle with adequate

free time to spend on avocational activities. Studies have found that a controllable lifestyle and remuneration are the two most prominent factors in speciality choice by modern medical graduates (Dorsey, Jarjoura and Rutecki 2003, 1176). As Charles Bryan alludes, newer generations of physicians are unwilling to "sell their life to medicine" (Bryan 2011, 465). It is understandable thus that medical professionalism, as defined earlier and which is characterised by devotion to the art of medicine – affirmed through the taking of an oath or ritual – would be in crisis, given that it appears to be incompatible with the values of the newer generation of medical graduates – arguably the product of the moral ideologies (based in broad-based, impartialist theories) which have been so zealously advanced by their forebears.

As has been elucidated, there are a multitude of reasons why medical professionalism in our contemporary culture is in crisis. Even though the majority of journal articles on professionalism originate from the United States of America and Europe, the situation for professionalism in South Africa is no different. Healthcare in South Africa is divided into a public and a private sector. Although the private sector only serves 15% of the population it is, naturally, burdened by the same conflicts of interest that are prevalent in healthcare in the United States of America – i.e. between commercialization and professionalism. Health insurance companies, major hospital corporations, big pharmaceutical companies and physician self-interest above that of the patient are problems that are rife in the South African private healthcare setting and that are having a denigrating effect on medical professionalism. The public sector in turn is not immune to this generalised loss of professionalism. There has been a raft of media stories in the last few years documenting the failures of medical professionals in the public service. This, including widespread corruption and mismanagement, have led to a generalised feeling of mistrust in the public healthcare sector (Maseko and Harris 2018, 22). It is estimated that only 41% of all physicians working in South Africa are employed in the public sector – looking after 85% of, invariably, the poorest and most vulnerable of the population (Wildschut 2010, 12). With this in mind, what has plunged the crisis of professionalism in the public sector even further into the doldrums has been the propensity of public sector medical professionals to simultaneously work in the private sector. Due to poor regulation and enforcement of accountability measures at all levels of governance, this dual interest has been allowed to reach crisis levels with the result that medical professionals often neglect their responsibilities toward their patients in the public sector, whilst earning a full salary, for lucrative financial benefits in the private sector (Shipley 2015, 18).

In conclusion, it is indisputable that medical professionalism is in crisis globally. It is not the purpose of this paper to contend with every cause for this loss of professionalism individually, although I believe all the causal factors are in some way connected to the moral framework undergirding, not only the medical profession, but, arguably, contemporary society at large. In the following chapter I will argue that medicine is special in a moral sense and should be viewed as a moral community distinct from all other occupations claiming to be professions or from society in general. To this end, I will argue that it is precisely for the reason above, as well as the special role of the "doctor" in society, that makes all attempts to ground medical professionalism in broad-based normative theories, including the much espoused principlism of Beauchamp and Childress, a fruitless endeavour.

Chapter 2: Medicine as a Moral Community and the Failure of Broad-based Theories

Medicine as a Moral Community

> Medicine is at heart a moral enterprise and those who practice it are de facto members of a moral community. (Pellegrino 1990, 222)

As Edmund Pellegrino, one of the most influential thinkers on medical ethics in the last half century states, the idea of medicine as being far more than mere contractual obligations individual practitioners have towards their individual clients is as old as time itself. Despite the largely successful attempts in modern times – invariably by leading bioethicists - to redefine medical practice according to the ethos of the market-place (Engelhardt and Rie 1988, 1086) or general moral standards (Veatch 1981, 106), we cannot ignore the fact that the medical profession has traditionally always seen itself as a moral community, remnants of which is still etched into the consciousness of the profession today (Pellegrino 1990, 222). As reviewed briefly in the previous chapter, the covenantal pledge of the ancient Hippocratic Oath embodies the idea of medicine being a moral community. After the invocation of the gods, the Oath enjoins:

> To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physicians oath, but to nobody else (Hippocrates 1923).

Despite the elitist and patriarchal tone – no doubt offensive to our modern sensibilities – it is clear that the Oath was intended to bind together those who share the knowledge of the art of medicine. Many of the moral precepts that follow in the body of the oath are the same moral values that physicians in subsequent ages and cultures – despite disparate world-views – espoused. As elucidated previously, it is this remarkable congruence – that has bound physicians for millennia - that suggests there is something intrinsic to the morality of medicine (i.e. the role of the physician) that transcends culture, religion and historical era (Pellegrino 1979, 34). If true, this would constitute the medical profession as being a moral community –

where medical professionals through the ages have shared a collective moral identity, commitments and responsibilities. This sense of sharing a common moral tradition, largely implicit since its significance has been downplayed in the modern era, is still visible today in the oath recited by medical graduates across the globe. For many it is this, and not the university degree, that constitutes formal entrance into the profession – an induction into a community far larger and older than the individual undertaking it (Markel 2004, 2029) (Pellegrino and Thomasma 1993, 36). It is thus clear that the medical profession – in the form it is described in the previous chapter – views itself as a moral community since its members are bound to each other through a set of commonly held moral precepts, whose purpose is something other than mere self-interest (Pellegrino 1990, 225). It is also a moral community since its existence is independent of who its leaders are or who its individual members are. This is evident in the way the profession and its moral ideals have been able to outlive individual bad actors or the manifold of bureaucratic institutions that have come and gone. This independence however means that the community is in a position where it can harness its power either for good or harm. To justify such a moral community then, it would have to use its power for good, even if the values of the broader society in which it functions conflicts with the moral purposes of the community. For medicine to be considered a moral community, it must be shown that the practice of medicine confers moral demands or ideals that are beyond those which characterise society at large – i.e. it is a role-specific moral practice (a concept which will be unpacked in great detail in chapter 3). Secondly, it must be shown that the medical profession is a force for good.

The first factor that justifies the medical profession to be a moral community – one with shared moral values that are not universalizable to society at large - is the nature of illness and the unequal relationship this state produces between physician and patient. In our modern liberalised world in which individual autonomy is afforded prominence, interactions between parties are governed largely by means of a contract; a relationship built on mistrust where each party is near equal, free to enter into such an arrangement and focussed exclusively on their own individual welfare (Tobin 2018, 1761). The nature of illness however renders the idea of a contract between physician and patient wholly inadequate. As Pellegrino elucidates, even the most self-sufficient person becomes anxious, fearful and dependent in the face of illness (Pellegrino 1990, 226). The predicament of illness forces a patient to trust the physician in a relationship they would have preferred not to have entered (Pellegrino and Thomasma 1993, 36). They lose all freedoms to pursue life goals, instead becoming entirely pre-occupied with

finding relief or cure. Due to the patient's desperate need to consult the highly specialised body of knowledge that the physician possesses, the patient's autonomy is also severely constrained – even more evident in the event of life-threatening emergencies. This state of intense vulnerability and desperate need – a universal phenomenon that is mostly absent in other spheres of democratic society – means the physician has immense power over the patient, consequently inferring certain moral responsibilities. The relationship that ensues between a physician and patient can thus not be contractual since the two parties are decidedly unequal (in varying degrees the power lies squarely in the hands of the physician), the patient is not completely free (certainly not in a life-threatening situation) and must implicitly trust that the physician will act in their best interest whilst eschewing their own or those of any third party. For Martin Tobin this is why the relationship between the physician and patient can only be understood in covenantal terms – a solemn and oath binding promise that the physician will put the interests of the patient first (Tobin 2018, 1761).

The second factor to consider in justifying medicine as a moral community follows on from this state of inequality and vulnerability to exploitation. The nature of medical decision making comprises both a technical as well as a moral dimension. It is not enough to be technically correct in the diagnosis and treatment options available. A physician must also be able to gauge what would be in the patients best-interest and advise accordingly. Despite the modern emphasis on respecting patient autonomy, the complexities of medical disease, the vast array of costly pharmaceutical and surgical options available - often aggressively marketed direct to consumers - and the intense anxiety and confusion that accompanies severe illness, places the patient in a position where they are extraordinarily reliant on the physician. This is even more the case in low to middle-income countries such as South Africa where the education and literacy level of the general populace is on average very low. To suggest, as Robert Veatch does, that the patient, or even his/her family, can truly, and in all circumstances, be fully equipped to make medical decisions entirely on their own – as if the patient views their own body as an object like a motor vehicle and the physician is merely the mechanic offering repair options – is ignorant of reality (Veatch 2009). This does not equate to an argument in favour of medical paternalism, but patients usually adhere to the advice or treatment plans of their physicians. In an age of spiralling medical costs, the patients must believe that their physicians will make medical decisions which are in their best interest since patients rarely have either the time, education or the financial means to shop around for a physician who will placate their individual needs (Tobin 2018, 1761). This is certainly not the case in countries providing a

universal healthcare system where patients are largely unable to choose their physician in any event. Patients must trust that their physicians' medical decisions are in their best-interest and not in the interest of pharmaceutical companies, the physician's own pocket or in the interest of the hospital's administration or government bureaucracies or medical insurance schemes; who are often more interested in curtailing cost than providing quality healthcare services.

The third factor to consider in justifying medicine as a moral community is the nature of medical knowledge. Unlike most other forms of knowledge, medical knowledge is not acquired for its own sake but is intended specifically for the care of the sick, and by extension the community (Pellegrino 1990, 227). To this end, society at large sanctions this attainment of knowledge through medical education by allowing exceptional breaches of privacy. Students are allowed to dissect human bodies, engage in medical experiments, practice clinical skills etcetera. As Edmund Pellegrino states poignantly, these privileges, often involving great breaches of privacy, cannot be bought like other commodities (Pellegrino 1990, 227). In addition to this, society also financially subsidises medical education and allows the medical profession substantial autonomy in accrediting medical journals, setting standards of care, adjudicating entry and expulsion from the profession etcetera. This makes physicians stewards of medical knowledge instead of its exploiters (Golde and Walker 2006, 3-20). According to Pellegrino and Thomasma, by accepting the privilege of a medical education, those who enter medicine, de facto become parties to a covenant with society – one that cannot be dissolved unilaterally (Pellegrino and Thomasma 1993, 36)

The final factor in justifying medicine as a moral community is the moral complicity involved in the practice of medicine. By way of the physicians covenant with the patient and the physicians role as stewards of medical knowledge, the physician becomes the final common pathway for whatever happens to the patient (Pellegrino 1990, 228). No order can be carried out, no drug given, no procedure performed, no policy observed, and no regulation imposed without the express consent of the physician. The physician becomes, ultimately, the final safeguard of the patient's well-being. As Martin Tobin illuminates, the physician cannot be a double agent – the physician can either serve the patient or himself/herself and/or some third party, but never both (Tobin 2018, 1761).

I have argued that there are good reasons to justify viewing the medical profession as a moral community – a community bound by distinct moral ideals that do not necessarily apply to

broader society. This view is strengthened by my exposition of the historical roots of medical professionalism which proved the remarkable congruence between differing cultures on the moral values that govern the practice of medicine and the role of the physician. Lastly, I argue that medicine as a moral community is a force for good, since its ethical ideals, its moral values, are morally grounded. To this end, I will argue in this thesis that a normative virtue ethics account, drawing in particular on Aristotle, Macintyre's concept of a practice and medicine's moral tradition, successfully undergirds the moral values of the medical profession, the role of the medical professional and subsequently medical professionalism. Before venturing towards arguing for virtue ethics, I will first elucidate why broad-based theories such as Kantian Deontology and Utilitarianism fail to ground the moral values, the ethical ideals, of the medical profession, including the role of the medical professional.

The Failure of Broad-based Theories to Undergird Medical Professionalism

> …an approach which judges the legitimacy of all professional behaviour directly in terms of broad-based moral standards will not do justice to the responsibilities and sensitivities proper to various professional roles, and a satisfactory ethic for a given profession must be able to recognise the particular roles, responsibilities, and sensitivities appropriate to that profession (Oakley and Cocking 2001, 2-3).

I have already discussed the moral values or ideals of the medical professional (i.e. medical professionalism) in chapter 1 of this thesis. As elucidated, this is not based on *de novo* contemplation but is steeped in a tradition stretching back thousands of years across vastly differing cultures from across the globe. The role of doctor, one of many social roles we find in society today, is an age-old role which Scribonius Largus already recognised thousands of years ago carried certain role-generated responsibilities which did not apply to the rest of society. The justification for this role, including its role-generated moral responsibilities is found in the medical profession being a moral community. This moral community is good since it is not self-serving, and its moral ideals aim at a higher good (Kass 1983, 1305). The last piece of the puzzle, to justify this moral good, is to ground its role-generated professional ethic, or ethical ideals, in a moral theory that is both cogent and action-guiding.

Immediately, a glaring problem for universalist theories such as Kantian Deontology and certain forms of Consequentialism – such as Utilitarianism - appears. A role-generated ethic

implies that it is specific to the role. Thus, what might be considered morally good, valuable or even obligatory in a specific role does not necessarily apply to the rest of society. In the rest of the chapter I will first charge that the moral values or virtues such as benevolence, compassion and altruism – foundational to traditional and most modern conceptualisations of medical professionalism – pose a serious problem for broad-based universal theories such as Kantianism and Utilitarianism. Consequently, I will argue that even if it could be argued that Kantianism and Utilitarianism can accommodate the values that encompass medical professionalism – I strongly believe they cannot - they are certainly unable to recognise the value of roles. Drawing on the failure of Kantianism and Utilitarianism to recognise the value of friendship, I will show how Kantianism and Utilitarianism fail to ground the role of the medical professional, especially within the context of the patient-physician relationship.

Kantianism and the Problem of Benevolence, Compassion and Altruism

Kantianism, a form of duty-based (deontological) ethics espoused by Immanuel Kant, is the theory, founded wholly in reason, that the morally right action is the one that is performed in accordance with a rule or maxim that meets the criterion set out by the categorical imperative. The formulations of the categorical imperative are: to act only by that maxim which can, at the same time, be willed to become a universal law (Kant 1785, 18); to act so that humanity is treated never merely as a means to an end, but at the same time, as an end in itself (Kant 1785, 47); to act as if every rational being was, through his maxim, always a legislating member of a universal kingdom of ends (Kant 1785, 49).

Kantianism has been highly influential, not only in moral philosophy but also political philosophy, especially through the work of John Rawls (Rawls 1971). That being said, Kantianism has had numerous detractors, predominantly because of its overly rationalistic approach to ethics that critics argue runs counter to our most basic moral intuitions and moral values.

> An action he (Kant) says, has no moral worth unless it be done simply as a matter of duty, and for duty's sake, without any liking for it being felt; and the character only begins to have value, if a man, who has no sympathy in his heart, and is cold and indifferent to others' suffering, and who is not by nature a lover of his kind, is nevertheless a doer of good actions, solely out of a pitiful sense of duty (Schopenhauer 1903, 49)

One of Kantianism's most fervent critics, Arthur Schopenhauer did not hold back in his disdain for the cold and emotionally indifferent nature he viewed Kant's duty-ethics to be when he penned these words two centuries ago. Despite defenders of Kant pointing out – arguably correctly – that this is a gross distortion of Kant's writings (Jensen 1989, 193), it is indisputable that Kant placed little to no value in emotions and acts flowing from feelings such as benevolence and compassion amongst others. In his *Groundwork for the Metaphysics of Morals*, Kant is at pains to state – in contrast to Hume - that feelings (inclinations as he terms them) or emotional dispensations such as sympathy are transitory, changeable and capricious and entirely unworthy of moral esteem - even if acting on them accidentally leads to the same right ends as those arising from duty (Kant 1785, 14). To illustrate, Kant uses the analogy of someone who, having previously been disposed to feeling sympathy for others, is now wholly overcome with his own grief as to be a misanthrope. If such a person still acts sympathetically towards others, not out of inclination (since he is unable to) but out of a sense of duty, then and only then, does his action merit our moral esteem. For Kant thus, our moral esteem ought only to be reserved for those characters who act out of a sense of duty (Cartwright 1987, 294). Critics point out however, that this runs contrary to our common perception that acts motivated by compassion, benevolence and love, etcetera, are valued higher than those done out of duty. Kant probably recognised this and in his later thesis, entitled *The Metaphysics of Morals*, he attempts to incorporate these virtues into his moral theory. In section two of his thesis, Kant discusses the duty of love toward others. By this he does not mean that we have a duty to love – since a duty to feel is an absurdity (Kant 1797, 203). No, Kant delineates love not to mean a feeling, a pleasure or even a delight in someone but a practical (actionable) love – which he calls benevolence and which ends in beneficence (Kant 1797, 244). Kant divides this duty of love into three distinct duties: beneficence, gratitude and sympathy, and then proceeds to extol what these duties entail. With regards to the duty of sympathy, Kant stresses that this cannot be out of a sense of compassion. For Kant the duty of sympathy only applies in the rational sense – in which one has the capacity and free will to share in others' feelings and proceed to help them. This duty of sympathy is thus contingent on one's ability to help the other person. Sympathy is only a duty if it can be actionable and lead to a beneficent end. If help cannot be given, then there is no corresponding duty to feel compassion or sympathy. For Kant, by feeling compassion (sharing in someone's pain) toward someone whom one cannot help, one is in fact adding to the sorrow and pain (evil) – and we have a duty not to add to the evil in the world. Instead, Kant proposes that, like the stoic, we ignore and reject feelings of compassion in those whom we cannot help since acting on these feelings would violate our duty not to increase the

evil in the world (Kant 1797, 250). It would seem strange to our conception of medical professionalism if, vis-à-vis Kant, the physician has a duty to treat patients in a cold and indifferent manner (the opposite of compassionately) if he/she concludes that the patient cannot actually be helped. Ironically, it is perhaps precisely in the case where nothing further can be done for the patient, that we would intuitively expect a 'good doctor' to show compassion and empathy.

There is something missing, and deeply unsettling, about this overly rationalistic account of morality, one that appears wholly divorced from human nature, human relationships and the intrinsic value we place on these humanistic emotions. Despite Kant lauding these feelings – he believes they may add value in motivating people to adhere to the moral law - he affords them no intrinsic moral worth. As David Cartwright poignantly states: "…his (Kant's) failure to attribute anything more than an extrinsic value to love, sympathy, compassion, and gratitude expresses a failure to appreciate morally important aspects of human personalities and relationships (Cartwright 1987, 296)." For many contemporary philosophers, emotions and morality are inextricably linked (Noddings 2013) (Nussbaum 1990).

Kant argues that it is precisely the capricious and unreliable nature of emotions that make them unsuitable to motivate moral behaviour – in contrast to obedience to duty and rational principle (Blum 2009, 3). This despite, as Augusto Blasi notes, that it is certainly not a given that a good, well developed, understanding of morality will guide or motivate one's actions (Blasi 1999, 1). Ironically, the argument in favour of cold and unfaltering duty to guide moral behaviour, in lieu of capricious emotions, was advanced most effectively by the Nazi regime during the first half of the twentieth century. In the words of the commandant of Auschwitz, Rudolf Hoess, the man responsible for the extermination of two million people in concentration camps, it became a necessity to ignore one's inclinations toward empathy and compassion in order to perform one's moral duty (Hoess 1961). This sentiment – of doing their duty and obeying the law irrespective of all else - was echoed by Adolf Eichmann at the Nuremberg trials where he cited Kant's categorical imperative as the motivating force behind his actions during the holocaust. Despite Hannah Arendt's erudite explication of how crudely Eichmann, and by extension the entire Nationalist Socialist regime, perverted Kant's moral theory, she still sombrely concludes:

> Whatever Kant's role in the formation of "the little man's" mentality in Germany may have been, there is not the slightest doubt that in one respect Eichmann did indeed follow Kant's precepts: a law was a law, there could be no

> exceptions…This uncompromising attitude toward the performance of his murderous duties damned him in the eyes of the judges more than anything else, which was comprehensible, but in his own eyes it was precisely what justified him, as it had once silenced whatever conscience he might have had left. No exceptions – this was the proof that he had always acted against his "inclinations," whether they were sentimental or inspired by interest, that he had always done his "duty." (Arendt 1963, 137).

Many scholars are not convinced that the leap from Kantianism to the atrocities committed by the Nazi's during the holocaust is as irrational as perceived (Wohlfart 2010) (Halberstam 1988). As Joshua Halberstam states: "…any moral theory which begins by disregarding human sentiment, caring and sympathy, might well end in the crematorium (Halberstam 1988, 52)."

Irrespective of whether this is a fair assessment, Kantian deontology's failure to appreciate the intrinsic moral worth of compassion, benevolence and altruism, that are foundational to medical professionalism, poses a serious problem for a Kantian deontological justification of medical professionalism as outlined in the first chapter of this thesis.

Utilitarianism and the Problem of Benevolence, Compassion and Altruism

> …the implications of act utilitarianism are wildly at variance with firmly held moral convictions, while rule utilitarianism, the most common alternative formulation, strikes most people as an unstable compromise (Scanlon 1982, 103).

Utilitarianism, a form of consequentialism, is the moral theory that states that the rightness or goodness of acts are judged by their positive production of good (or the best) states of affairs – whereby the best states of affairs is what would (as a consequence of action) produce the maximal happiness or maximal pleasure (Foot 1985, 196). The two most prominent Utilitarian theories are Act-Utilitarianism: the right action is the one which produces the most net utility, and Rule-Utilitarianism: the right action is the one which follows a justified moral rule (where the moral rule would produce more happiness or pleasure than other/ no rules).

Before venturing toward discussing the relationship between utilitarianism and benevolence, compassion and altruism, it is worthwhile to note that recent empirical studies conducted in the

field of psychology and neuroscience have concluded that utilitarian decision makers showed significantly reduced levels of empathic concern for others, a trait consistent in those with a high measure of antisocial personality (Bartels and Pizarro 2011) (Koenigs, et al. 2007) (Ciaramelli, et al. 2007) (Moll and de Oliveira-Souza 2007). Gleichgerrcht and Young, in their study concluded the following: "Indeed, how we resolve moral dilemmas may rely not simply on abstract reasoning and cognitive control but also crucially on our empathic concern for potential victims (Gleichgerrcht and Young 2013, 8)."

Despite a small number of scholars questioning the results of these studies (Baron, Gürçay and Luce 2018), the evidence strongly suggests that utilitarian moral judgements occur more frequently in the absence (such as in patients with significant brain damage) or suppression of emotion than when one's affect is not regulated (Lee and Gino 2015, 49). If true, then it poses a disconcerting problem for any attempt to ground medical professionalism in utilitarianism. A benevolent, altruistic and compassionate physician would be wholly counterintuitive to a society wishing to ground morality in utilitarian principles – a robot programmed to obey rules or a person with certain cognitive disabilities would be far better suited. Similar to Kantianism then, Utilitarianism shows a remarkable disconnect from reality in being unable to fully appreciate, amongst others, the moral value of character and human relationships. Utilitarianism also struggles since we generally admire traits such as benevolence, compassion and altruism in terms of their non-consequentialist or intrinsic value, and not only their consequentialist or instrumental value. It matters that someone feels compassion for compassion's sake, and not only for the sake of its ends. As Bernard Williams states:

> No one can hold that everything that has value, of any category, has it in virtue of its consequences. If that were so, one would just go on for ever and there would be an obviously hopeless regress. That regress would be hopeless even if one takes the view, which is not an absurd view, that although men set themselves ends and work towards them, it is very often not really the supposed end, but the effort towards it on which they set value (B. Williams 1973, 82)

Generally, we value benevolent or compassionate or altruistic acts more precisely because the agent was moved by benevolence, compassion or altruism and not merely for the ends it brought about or because it is a duty in the case of Kantianism. By all accounts, utilitarianism is unable to appreciate this central fact of human existence.

Nevertheless, utilitarianism as a moral theory has dominated – along with Kantianism - contemporary philosophical discourse for the last three centuries. With regards to medical professionalism then, utilitarianism is compelled to argue that it is irrelevant whether the physician is inclined toward – or possesses the virtues of – benevolence, altruism and compassion, as long as the physician's acts are, as a consequence, benevolent, altruistic and compassionate. To this end, utilitarianism makes strong arguments in favour of benevolence, altruism and compassion. For the sake of brevity, I will focus specifically on altruism as it will be enough to illuminate the problems utilitarianism faces regarding the virtues foundational to medical professionalism.

In his seminal article *Famine, Affluence and Morality*, the erudite moral philosopher Peter Singer puts forth a utilitarian argument for altruism. Singer argues – he calls it a strong form of utilitarianism - that we have, as individuals, a moral responsibility to share our affluence with those who are less well off, including those in other countries. He states that we morally ought to prevent or ameliorate bad things from happening unless by doing so we sacrifice something of comparable moral value (Singer 1972, 241). For Singer, this moral ought should be understood – applying utilitarian principles – in agent-neutral terms so that proximity-to-the-problem or the presence or absence of any personal connection is irrelevant. He compares a Westerner spending money on luxuries when he/she could have spent it on ameliorating the plight of those suffering in a developing country to someone walking past a shallow pond in which a child is drowning and refusing to pull the child out. Many see Singer's argument as requiring too much of humanity – a common criticism of utilitarianism – and have labelled this as radical altruism. I am not certain if it really is as radical as some purport it to be, the story of Ananias and Sapphira in Acts 5 of the New Testament – in which Ananias and Sapphira die because they do not sacrifice all their money to the apostles as was purportedly morally required of them as followers of Christ (Acts 5:1-10, NIV), seems far more radical – yet such narratives are integral to Judaeo-Christian faith systems that are supposedly adhered to by large sections of the world.

It is not certain within Singer's view what would constitute something of comparable moral value. As illuminated in the chapter on medical professionalism earlier, altruism is a foundational moral value for the medical professional. To illuminate a possible limitation of Singer's "radical" altruism would be the example of a hospital being attacked by a violent gang who is looking for a rival gang member. A Paediatric ICU physician is looking after a critically ill child who requires intensive care when he learns that the armed gang might be heading to

the ICU. On Singer's utilitarian altruism, it is perhaps entirely reasonable for the physician to run away and leave the critically ill child to his/her own fate – certainly the risk to the life of the physician outweighs the potential harm that may befall the child. Even if the child were to die because the physician has left, then it might still have been morally acceptable since the utility of the physician staying alive – and being able to save more lives in the near-foreseeable future – outweighs the immediate utility of the child. Intuitively, the fact that this is morally right according to utilitarianism is not so obvious – although this may have more to do with altruism and a role-generated ethic than general altruism (to be discussed). The same analogy could be used for a lifesaver who doesn't attempt to rescue a drowning child because there is a shark nearby. Singer's utilitarian altruism would again not apply, although most people would probably judge the lifesavers actions negatively.

In the midst of writing this thesis, the world is gripped by the novel Corona virus (Covid-19) pandemic. Medical professionals are at the forefront of the fight against Covid-19 which has caused the deaths of hundreds of thousands across the globe. The risk to the lives of these professionals is very real – many have lost their lives to the virus – and they are regularly hailed as heroes by the global community for their altruistic service and sacrifice (University of Witwatersrand 2020) (El Chaer 2020) (Menon 2020) (Wetsman 2020). The risk the virus poses is grave, and most countries have instituted mass quarantines and lockdowns to try and curb the spread of the virus. The economic and health impact the virus has ravaged upon even the most sophisticated economies around the world has already been profound and the future remains uncertain at best (McKibbin and Fernando 2020). Despite the immense risk to their own safety – and those of their family's – medical professionals are still pitching up to work and serve everyday (whilst the majority of the population is isolated at home). Without minimising the sacrifice medical professionals make every day around the globe, it seems strange to describe their actions as "heroic" – thereby implying that their actions are somehow above what would ordinarily be morally required of the medical professional. Certainly, the sacrifice these medical professionals make are far above what Singer requires one to make in his conception of utilitarian altruism. Yet it does not seem to be beyond the pale to suggest that society would judge the medical professional morally blame-worthy who decides to rather stay-at-home than go to work to help those who desperately need aid – an act that might be construed as morally right on Singer's view. Similarly, the Covid-19 pandemic and the response by medical professionals in the face of this global pandemic has exposed the moral theoretical frailties of Kantianism and the much-espoused Principlism - to be discussed later.

Inspired by Singer's utilitarian philosophy of altruism, a young philosopher at Oxford University named William MacAskill co-founded a movement called "Effective Altruism" which – in line with utilitarian thinking – seeks to do the most good it can by using empirical research to decide which charities to donate to, which careers to follow, which companies to invest in and which goods to consume in order to maximise utility (Srinivasan 2015, 3). In his book, *Doing Good Better*, MacAskill argues, amongst many arguments, that we shouldn't follow our passions in deciding which career path to follow but which career will allow us to do the most good. He reasons that a doctor in the developed world, where there are an abundance of doctors, offers far less value, and saves fewer lives, than a financier who donates most of his money to the Against Malaria Foundation (MacAskill 2015). He recommends that when deciding which career to follow the morally right choice would be – in this example - to become a financier. He largely ignores the bad social effects that many of these lucrative careers have, arguing that someone would have done it anyway, thus it is morally irrelevant. Bernard Williams advances a similar example of a down-on-his-luck chemist who is offered a job at a laboratory which is doing research on biochemical weapons. The chemist needs the job to feed his ailing family. The chemist feels uncomfortable doing research on something he finds morally abhorrent but if he does not take the job then it will certainly go to a contemporary of his who has no such qualms about advancing research in biochemical weapons and in fact has quite a zeal for it (B. Williams 1973, 97-99). Bernard Williams elucidates that not only would a utilitarian response be that the chemist should take the job, but furthermore that this is obviously the right thing to do. It is not at all clear however that this is in fact the correct answer, or that it is nearly as obvious, and it completely ignores a consideration of the chemists own moral integrity – a problem utilitarianism struggles to contend with.

It is not only in career choice that MacAskill's utilitarian approach to altruism is applied so stringently. According to MacAskill, when giving to charity it is most important not to allow one's feelings, inclinations, or personal affections to get in the way of reason and empirical facts. It is most important (read morally right) to give to the charity for which one's donation will provide the greatest benefit to the greatest number instead of the one which is tugging at one's heart but is not as cost-effective. He writes this about a visit to the Hamlin Fistula Hospital in Addis Ababa, Ethiopia:

> I'd hugged the women who suffered from this condition, and they'd thanked me for visiting them. It had been an important experience for me: a vivid firsthand demonstration of the severity of the problems in the world. This was a cause I

> had a personal connection with. Should I have donated to the Fistula Foundation, knowing I could do more to help people if I donated elsewhere? I do not think so. If I were to give to the Fistula Foundation rather than to the charities I thought were most effective, I would be privileging the needs of some people over others merely because I happened to know them. That would be unfair to those I could have helped more. If I'd visited some other shelter in Ethiopia, or in any other country, I would have had a different set of personal connections. It was arbitrary that I'd seen this problem close up rather than any of the other problems in the world (MacAskill 2015).

There is an eery absoluteness with which MacAskill concludes that it would have been wrong to donate to the fistula hospital merely because he had felt a personal connection to the sufferers there and an inclination to help, when there were more worthy causes elsewhere. To Bernard Williams' point, it is not at all obvious that this is the morally right answer. It is not at all certain that MacAskill would have felt a personal connection or an inclination to act, had he visited the other charities either. The need, albeit seemingly easy for MacAskill, to suppress his inclinations so that cold reason could prevail is disconcerting to say the least. It is no stretch to imagine that the altruistic good he is trying to promote would have been lost on those suffering from the debilitating obstetric fistulas at the hospital. One can imagine the probable indignation and disgust experienced by these women upon learning that the personal relationship they had built up with MacAskill, culminating in a warm embrace, had counted for nothing in his dispassionate rationalisation that they were simply not worthy enough of his help when compared to others. His altruism would arguably have been perceived as little more than cold, calculated and almost callous indifference. Despite the good that comes from movements such as those advanced by MacAskill, its underlying philosophy doesn't fully encapsulate what we value about altruism and the acts that ensue from it.

Kantianism and the Problem of Roles

I have discussed earlier in the chapter the problems that Kantianism has with the moral values or virtues that are foundational to medical professionalism – I have only discussed the three of benevolence, altruism and compassion but there are of course others – and the problem of moral motivation through duty alone. Although I am not convinced that Kantianism can, generally speaking, encompass the entirety of what we commonly appreciate about benevolence, altruism and compassion, and the acts that flow from these inclinations or traits, it can be argued that

Kantianism does broadly have a role for these virtues within the framework of duty – albeit not a primary role. Even if I were to hypothetically accept this, Kantianism is still not able to appreciate these virtues in the context of the role of the medical professional. In the following section I will argue that Kantianism is unable to recognise the moral value we commonly place on roles – such as the role of friendship – and by extension is thus unable to value the role of the medical professional, especially the distinct role in the doctor-patient relationship and the incumbent moral values.

> It is doubtful that ethical theory and practical deliberation can establish precise, determinate limits on the scope of obligations of beneficence. Attempts to do so will involve setting a revisionary line in the sense that they will draw a sharper boundary for our obligations than the common morality recognises (Beauchamp and Childress 2013, 209).

In their landmark work, *The Principles of Biomedical Ethics*, Beauchamp and Childress, discussing the principle of beneficence, conclude that it is difficult to justify a positive duty or obligation of general beneficence beyond what they describe as the duty to rescue – in which one is obligated to rescue someone if one is able to do so at very little cost/risk to oneself (Beauchamp and Childress 2013, 207). Fortunately, Beauchamp and Childress recognise that this is wholly inadequate when discussing the moral responsibilities a medical professional has toward his/her patient – a realisation made even more stark by the Covid-19 pandemic raging across the globe in 2020, for it would be ludicrous to suggest that every medical professional is acting in a supererogatory manner where their actions are beyond their moral duty (there is something distressingly inadequate about a moral theory if it requires a large portion of a society to act above the moral requirements of said theory merely for the society to exist in any acceptable state). Beauchamp and Childress note in passing that there are specific obligations of beneficence based on special moral relations and roles, but they make no attempt whatsoever to sustain this belief within their deontological (Kantian) framework. Instead, sensing that their argument requires some sort of explanation for the specific duty of beneficence for healthcare workers, they advance a reciprocity-based justification. Beauchamp and Childress argue that modelling beneficent care of patients, by healthcare professionals, on altruism and personal commitment is misconstrued and should be rooted in a moral reciprocity of receiving and giving in return (a contract of sorts). According to Beauchamp and Childress, medical professionals owe a great debt to society (for formal education and training in hospitals) and to their patients (for learning gained from both research and practice) and thus have specific

obligations of beneficence which exceed that ordinarily required by the common morality. I agree with Beauchamp and Childress that this could be a neat way of circumventing the issue deontological moral theories have with specific duties. There are however still several problems with this theory – which is very contractual in nature. Firstly, this is decidedly not Kantian since this duty is not borne out of a duty to a universal moral law – it only applies to medical professionals who have incurred a debt owed to their community. Secondly, this does not address the problem of moral motivation that Kantian/Deontological ethics struggles with. Thirdly, it is not clear if this indebtedness is necessarily accrued by all medical professionals. Certainly, in many parts of the world, medical education is private, and the medical student bears the brunt of the financial burden for educating him/herself. Furthermore, patients are generally not obligated to avail themselves to medical students for research and learning purposes. With enough money it would ostensibly never be necessary for someone to subjugate themselves to the unlearned prodding of medical students. Often, in the research environment especially but also with regards to the education of medical students, there are financial or health incentives for the patients. Fourthly, it is not clear if these duties of beneficence would apply to illegal immigrants since they are not typically regarded as part of the community to whom a debt is owed – certainly the governments in many countries do not provide them with even very basic services, including healthcare – yet it is generally considered that medical professionals are obligated to be benevolent to all regardless. This even includes enemy combatants – to whom no-one would argue a medical professional has a contractual duty (based on reciprocity) of beneficence. Lastly, a contractual duty based on reciprocity seems woefully inadequate to justify medical professionalism during a time of crisis (such as a war or the current Covid-19 pandemic) – especially since these are extraordinary events.

> …any ethical theory rests importantly on its capacity to recognise great human goods, such as friendship, and the problems which impartialist theories like consequentialism and Kantianism have in accommodating friendship may provide important insights into the capacity of these theories to accommodate the value and normative force of various professional roles (Oakley and Cocking 2001, 39).

As observed, there is good reason to think that Kantianism cannot ground the moral ideals required of medical professionalism. This claim is furthermore sustained by the fact that Kantianism is unable to appreciate the value of roles such as friendship and by extension the very role of the medical professional. Kantianism has both theoretical and practical issues

related to the role of friendship. In his famous example, Michael Stocker tells one to imagine lying in a hospital recovering from a long illness. Smith, a friend who has travelled from afar, comes to visit. You are convinced that Smith is a fine person and a good friend for making the effort to cheer you up in your time of distress. You thank him wholeheartedly, but he protests that he was merely doing his duty. You shrug it off as him being self-deprecating, but the more you talk the more you realise that it is true. He did not, essentially, come to visit because of you, or because you are friends. No, he believed it to simply be his duty, perhaps as a Christian or a Communist or because he could think of no-one better that needed cheering up (Stocker 1976, 462). Stocker's example is easily translated to the relationship between medical professional and patient – such as a doctor making a house visit purely out of cold indifferent duty. Whereas the Kantian duty is toward the universal moral law, the Christian's toward God and the Communist toward Marxist ideology, the moral dynamics that surround friendship are aimed at the other person – similar to the responsibilities the medical professional has towards his/her patient. In Stocker's words, within Kantianism it is the external value (the something other than the person him/herself) which is valuable, whereas real friendship and the role of friend is defined by its internal values (the person-as-valuable) which is of moral worth (Stocker 1976, 459).

Furthermore, as Oakley and Cocking illuminate, in so far as Kantianism is an impartialist moral theory, it is often at odds with the partial nature of friendship and by extension the role of the medical professional. For them it seems a commonly-held truism, owing to the partial nature and affection we have for our friends, that we would sometimes be prepared to break a moral commitment and say lie, or cover, for them (Oakley and Cocking 2001, 68). Even if we do not need to break a moral commitment in order to benefit our friends, there is good reason to believe that the good we do for our friends, precisely because they are our friends and because we have a personal affection for them, cannot be expressed within Kantian Categories (Blum 2009, 5). Charlies Fried, in his criticism of Kantianism and Utilitarianism to appreciate the role of the medical professional, has this to say regarding the parallels between friendship and the patient-physician relationship:

> …the ethical life of human beings, the values they perceive and follow, inhere in the concrete actions they perform and the concrete relationships into which they enter. It is these which allow a man to live in the present and to give ultimate, intrinsic value to the things that he does. Traditionally the doctor has seen himself as a person who stands to his patients in a relation that is at least

> analogous to that of friend or lover. To be sure, the relation is less intense and pervasive, but it is analogous because it has its own integrity, and it demands, at least within its more circumscribed ambit, complete and unstinting devotion (Fried 2016, 87).

An example of this unstinting devotion (a fundamental analogous with that of friendship and love) which characterises the physician-patient relationship has been brought to the fore with the Covid-19 pandemic. Even in the midst of immense danger, the physician is still devoted to his/her patient (with the aim of saving their life) – despite the fact that the patient could potentially kill the physician (Wetsman 2020) (Adams and Walls 2020). It is this level of devotion – at a level where one places one's own life in jeopardy to aid another – which is usually only confined to intimate filial and romantic relationships and/or friendships.

James Drane concurs with Charles Fried that a good physician is one who is willing to be friends with his/her patient. He describes the doctor-patient relationship as one involving several personalistic moral dimensions in the form of a spiritual, affective, social and even a religious dimension (Drane 1995, 23). In so far as this is true (even if only partially), Kantianism cannot justify these moral dimensions to the patient-physician relationship – dimensions which have historically been part and parcel of the moral ideals of the medical professional and which are still relied upon as the Covid-19 pandemic suggest.

Although not an exhaustive criticism of Kantianism's failure to appreciate the role of the medical professional, I have shown that Kantianism cannot properly value, morally speaking, the role of friendship and by extension the medical professional (within the doctor-patient relationship which forms the bedrock of medical practice).

Utilitarianism and the Problem of Roles

If Kantianism is unable to appreciate the role of friendship and by extension the role of the medical professional (which is often framed in terms of partialist moral obligations) then Utilitarianism would struggle even more so. It is obvious that Act-Utilitarian's, not only Benthamite versions (Bentham 1789) but also such modern theories as those advanced by Peter Singer and James MacAskill, would not be able to appreciate the role of friendship as a common human good – since Act-Utilitarianism is only concerned in promoting maximum utility in an agent-relative, impartial manner. Friendship by its very definition is agent specific.

My friendship with another is never contingent on us promoting maximal utility – it would be particularly precarious grounds on which to base a friendship since it could end at any moment for reasons that might even be trivial. According to Oakley and Cocking, friendship requires, in certain contexts, that we do not aim at maximising the abstract good but that we focus on the good of the friend him/herself (Oakley and Cocking 2001, 40).

This could be extended to the doctor-patient relationship. Under an Act-Utilitarian understanding, the relationship would be contingent on it promoting the greatest impartial good. Undoubtedly, this would render palliative or end-of-life care not only a worthless endeavour but even morally wrong. A doctor treating a homeless man in New York City with malignant prostate cancer, who has no family or relatives and has only a week to live, whilst there are children dying in a neighbouring developing country from preventable causes, would, in an Act-Utilitarian sense, be morally wrong.

To this end, very few scholars advance Act-Utilitarianism (or direct utilitarianism) as a viable theory to justify common human goods such as friendship. In reply to the criticisms I have identified in the chapter thus far, consequentialists argue that: "a consequentialist agent need be committed to maximisation of the good only as an objective criterion of rightness by which their actions can be assessed, rather than as directly providing a motive or a purpose which such an agent is consciously to adopt in performing any action (Oakley and Cocking 2001, 41)."

This is in line with the observation of one of the most influential utilitarians, Henry Sidgwick:

> …the doctrine that Universal Happiness is the ultimate standard must not be understood to imply that Universal Benevolence is the only right or always best motive of action. For, as we have before observed, it is not necessary that the end which gives the criterion of rightness should always be the end at which we consciously aim: and if experience shows that the general happiness will be more satisfactorily attained if men frequently act from other motives than pure universal philanthropy, it is obvious that these other motives are reasonably to be preferred on Utilitarian principles (Sidgwick 1962, 413).

Although this appears a clever way of circumventing the problems of motives and aims which plague utilitarianism – especially in relation to friendship – there is good reason to think that this is not the only problem with utilitarianism, even indirect utilitarianism.

To show that utilitarianism can justify common goods such as friendship, Peter Railton advances an indirect utilitarian theory he calls sophisticated hedonism. For Railton, although the overarching ends of life at which one should aim is the production of maximal agent-neutral good (objective consequentialism), the way this is achieved is not constrained to every action being measured on the utilitarian calculus. As Railton writes: "… (One should) lead one's life in such a way that an objective consequentialist criterion of rightness is met as nearly as possible. In a given instance, this criterion might be met by acting out of a deeply felt emotion or an entrenched trait of character, without consulting morality or even directly in the face of it (Railton 1984, 170).

For Railton thus, a sophisticated utilitarian would regulate their dispositions and conduct so that their lives maximise the good. In terms of friendship or love, Railton advances this example:

> Juan has always seemed a model husband. When a friend remarks on the extraordinary concern he shows for his wife, Juan characteristically responds: "I love Linda. I even like her. So, it means a lot to me to do things for her. After all we've been through, it's almost a part of me to do it." But his friend knows that Juan is a principled individual and asks Juan how his marriage fits into that larger scheme. After all, he asks, it's fine for Juan and his wife to have such a close relationship, but what about all the other, needier people Juan could help if he broadened his horizon still further? Juan replies, "Look, it's a better world when people can have a relationship like ours and nobody could if everyone were always asking themselves who's got the most need. It's not easy to make things work in this world, and one of the best things that happens to people is to have a close relationship like ours (Railton 1984, 150).

It is not at all clear that the relationship Juan has with Linda can still be considered a friendship (or one of love), for the overarching concern remains the maximisation of agent-neutral good. Juan's argument is contingent on the fact that he can satisfy Linda's needs better than anyone else and that it would be a better world if everyone does the same. If, however, Juan is unable to satisfy Linda's needs any longer, or Linda does not require anyone else to satisfy her needs, then Juan would, morally speaking, have to terminate the relationship. It is not clear however, that a relationship such as this – with its terminating conditions – could be considered a true friendship or one of love at all.

It is clear from this brief account that Utilitarianism has formidable problems in accommodating common goods such as the role of friendship or love. Its insistence on maximising agent-neutral and impartial good, whether directly or indirectly, fails to recognise that which we value in friendship and by extension the role of the medical professional in the doctor-patient relationship.

Principlism and the Problem of the Role of the Medical Professional

The four principles of biomedical ethics as formulated by Beauchamp and Childress have dominated medical ethics since their publication in the 1970's. Very few discussions within healthcare ethics do not include substantial reference to the four principles, and modern medical undergraduates are taught to almost exclusively use the four principles in any medical moral deliberations. Despite some critics arguing that principlism is descriptive and carries little to no normative moral force (Corcoran, et al. 2016, 225), Beauchamp and Childress apply the principles to a discussion of the professional-patient relationship, appraising the "rules" of veracity, privacy, confidentiality and fidelity (Beauchamp and Childress 2013, 302). It is noteworthy that they do not discuss virtues such as benevolence and compassion, arguably because these would be seen as moral ideals – praiseworthy but not obligatory (although the Covid-19 pandemic has proven the necessity of medical professionals embodying these moral values). They do however discuss obligations of fidelity – which they conceive as giving the patient's interests priority over the interests of the physician and third-party interests. This is similar to the traditional value of altruism discussed earlier which the physician charter on medical professionalism also acknowledge (ABIM Foundation 2002, 115). Beauchamp and Childress baldly state that few today consider fidelity as being a fundamental moral norm in healthcare and that in practice fidelity has never been as pristine as traditionally conceived (Beauchamp and Childress 2013, 324-325) – the fact that it has not been practiced as ideally, especially in contemporary practice, as traditionally conceived seems a particularly poor reason to discard it as a fundamental moral norm, especially in light of the current Covid-19 pandemic. To the latter they cite third party interests such as governments, healthcare institutions, the military, etcetera as posing conflicts of interest to obligations of fidelity. Although these are dilemmas within broader healthcare – which encompasses more role-players than merely medical professionals - it is uncertain how principlism gives any normative force to these obligations within the professional-patient relationship. As critics have cited, Principlism merely describes the moral quandary in a formulaic sense without offering much, if any, action-

guidance (Huxtable 2013, 43) (Olivieri 2018, 4). Beauchamp and Childress in their chapter on the professional-patient relationship do not attempt to undergird the obligations of said relationship using the principles – similar to most of the other chapters they view these obligations in a decidedly deontological sense – they simply describe the moral complexities of these relationships, within contemporary Western culture, using the language of principlism. The ABIM's usage of the four principles as the fundamental principles of medical professionalism in the new millennium are as impotent a normative force as they are wholly inadequate to ground the professional-patient relationship. At best the principles offer the moral minimum required of a professional which, as Corcoran et al have noted, are woefully inadequate to ground that which not only society, but especially patient's and medical undergraduates, value in the medical professional (Corcoran, et al. 2016, 226). Professing the moral minimum, in the name of principlism, seems a far cry from the moral ideals the medical profession has for millennia set itself, and which tens-of-thousands of medical professionals are embodying currently during the global Covid-19 pandemic. Ultimately it forms part of the greater reason – whether deliberate or not - causing the denigration of medical professionalism globally.

Chapter 3: Virtue Ethics and the Role of the Medical Professional

As I have shown in chapter 2 there are good reasons to believe that medicine is a moral community distinct from broader society. The moral values or responsibilities of those practicing inside the community are thus different to those moral norms applicable to broader society. Of course, the individuals practicing inside this distinct moral community, also reside within the broader society with its own set of moral norms. It can thus be understood that those inside this distinct moral community occupy a role whenever they practice as a member of this moral community. This leads to the need to articulate a role-specific normative moral framework that undergirds this community. To this end, I have already endeavoured to show that neither of the two most dominant moral theories, namely Kantian Deontology and Utilitarianism, are able to appreciate the value of roles or a role-generated ethic, nor the moral ideals or virtues that have for millennia been considered foundational to those practicing in the medical moral community and which are still considered of the utmost value today.

In the first part of the chapter I will discuss the peculiarity of roles, a phenomenon that pervades our moral lives. I will argue that although the medical professional is a social role, like many others, there is something morally distinct to this role which is not amenable to the capricious whims of a postmodern society. To this end, I will first discuss the relationship between roles and character. I will then discuss how an understanding of the aim of medicine informs its practice and subsequently the virtues or character traits conducive to this. I will draw heavily on the work of Alasdair Macintyre and an Aristotelian conception of Virtue Ethics as well as the work of Oakley and Cocking and Pellegrino and Thomasma. I will then discuss how a moral tradition of medicine gives a comprehensive normative account of a virtue theory for medical professionalism by not only sustaining the virtues but also providing its normative force.

The Peculiarity of Roles

I have already shown in chapter two that there are good reasons to consider the role of the medical professional to be morally distinct from the common morality which applies to broader society. There are two ways in which this is distinct. One, what is expected of a professional often supersedes that which is demanded by the ordinary morality and is not satisfactorily explained/grounded by referring to a mere contract or to a theory of reciprocity. The discussion

of the obligation of beneficence in the face of risk of harm to the professional is an example of this – especially pertinent given the Covid-19 pandemic. Another would be the moral responsibility of the professional to his/her patient. Second, what is sometimes considered morally wrong in broader society may be morally permissible or even obligated within a certain role. I have already shown that a true friendship might be categorised by one lying for one's friend. A lawyer is ordinarily considered justified in using deception and humiliation in defence of their client (Freedman 1966) (Dare and Swanton 2020). A doctor is justified in asking difficult, searching and intimate questions to their patients which would ordinarily be considered entirely inappropriate (Oakley and Cocking 2001, 119).

Roles pervade our lives, such as the role of a parent or a spouse or a friend. These are often referred to as social positions which any number of persons can take up (Dare and Swanton 2020, 13). Professional roles are no different and have for centuries formed an integral part of our moral life. The role of the medical professional is a distinct entity with unique role-generated moral values. Michael Hardimon, in his discussion of role-obligations, identifies two kinds of role-obligations which he terms contractual and non-contractual (Hardimon 1994, 337). It is obvious that the role of a medical professional would, using his terms, be a contractual role since it is freely entered – unlike the non-contractual role of a son or daughter into which one is born. Although Hardimon's discussion is deontologically orientated, he points out that contractual role-obligations should not be understood using the traditional conception of a contract. Where a contract is usually made between people, this contract is made between an individual and a social institution. The role of a father derives its role-obligations from the social institution of fatherhood. Similarly, the role of a medical professional derives its obligations or moral values from an institution, the medical profession – which Edmund Pellegrino describes as a moral community (Pellegrino 1990). As Berger and Luckmann have shown, these institutions are derived from well-established patterns that have emerged over a period of time so that these roles are not subject to the preferences or habits of individuals but are more a case of "how these things are done" (Berger and Luckmann 1991, 77). Some of these roles are normatively thin, in that they are general groupings of people displaying typical behaviours (Dare and Swanton 2020, 15). An example would be the criminal or the college graduate. We may identify certain behaviour, traits and skills that are typical of the college graduate yet there are not moral values or obligations we generally expect the college graduate to live up to. In contrast, the role of the medical professional, like the role of the judge or the father or the spouse is normatively thick. Not only do we distinguish what

these role occupants characteristically do, but also what these role-occupants should do. Closely related to this are the enablements and constraints generally attached to these normatively thick roles. Only someone occupying the role of a judge can sentence someone to life imprisonment for example, whilst the same judge is constrained from receiving gifts or for showing bias towards any one party – unlike fathers who are expected to show bias towards their children. This normative account of roles however, one born merely from patterns that have emerged over time, is founded, in a certain sense, on precarious moral ground. For one, it is entirely possible for new patterns to emerge that would redefine the role irrevocably or for conflict to arise between members occupying the same role.

> To say that social roles are enduring is not to say that they cannot change, for roles do change along with the social institutions of which they are a part. Human history is, among other things, the story of the transformation of social roles. Nor is there any incompatibility between saying that social roles are enduring and recognizing that they can be changed and that we can change them. To say that roles are socially defined is to say that they are defined by us, that we, as a society, have defined and continue to define them in a particular way (Hardimon 1994, 355).

This is especially pertinent in contemporary culture where the obligations generally associated with certain roles are increasingly loosely defined creating greater room for variability. This poses a danger in itself – if one believes that roles are valuable – for the more freedom there is to express one's preferences within a role, the more likely it is that the role would cease to exist, at least in a moral sense. Numerous scholars advocate for this, arguing that roles – especially professional roles – should be abandoned in lieu of a broad-based universal morality that applies to everyone equally (Veatch 1981). As Oakley and Cocking illustrate however, it is particularly difficult to see how a lawyer, whose role primarily demands of him to zealously advocate for his client above almost all other considerations, could be grounded in a broad-based moral theory (Oakley and Cocking 2001, 121-129). If the lawyer knows his client to be guilty, should he then not have to give up the case in the name of justice? Similarly, I have shown above how a broad-based account of the role of the medical professional fails to adequately capture what is valued about this role. Should a medical professional acquiesce to the demands of a patient simply because the patient is a paying client?

In contemporary culture, social roles and their traditional role obligations are being increasingly challenged. The extent to which these challenges are successful in bringing about change is in large part due to the fact that they are mere social constructions which differ depending on culture or time-periods - their moral grounding is often precarious at best, absent at worst. Centuries ago, women were expected, in their role as females and mothers, to tend to the home and bear children. Men had authority over women, were expected to be the head of the household and to work in order to provide. Fathers were expected to be aloof to the emotional needs of their children – lest they become weak-willed - and to instil discipline with an iron fist. Many of these role-generated values or obligations have changed in recent years, however. One is no longer considered a bad mother because one has a career, whereas a father is considered bad if he is aloof to the emotional needs of his children or physically abuses them. The argument that one's father did it that way and his father before him etcetera, is no longer considered a good enough justification (on its own) for how one should conduct oneself in a specific role. It is thus imperative that if one wants to justify a specific role, with its role-specific moral values or obligations, to ground it in a moral theory that is not only coherent and normative but also able to withstand the assault from an increasingly pluralistic society. To this end, which is also in part the aim of this thesis, it is important to first understand the relationship between roles and character.

Roles and Character

Character, as defined in the Oxford English Dictionary, is the sum of the moral and mental qualities that distinguish an individual or a group (OED 2019). In his discussion of the relationship between roles and character, Glen Pettigrove identifies four purposes for which we use the concept of character: predicting future action, explaining past action, evaluating one another and saying who someone is (Pettigrove 2020, 19). According to Pettigrove, knowing someone's role is often imperative in order to conceptualise character and its four purposes adequately. In terms of predicting future actions, certain role occupants have a propensity to act in certain ways – i.e. they act in ways that are characteristic of the role (Mallon 2003, 336). This is in part due to the expectations and obligations generally associated with the role: i.e. it is expected of a good friend to be supportive – emotionally, physically or otherwise – towards a friend that is suffering. It would be considered entirely uncharacteristic of a good friend not to assist his/her friend at the roadside with a flat tyre if he/she happens to drive by. As Berger and Luckmann show however, it is not enough to merely know the routines necessary for the

"outward performances" of a role. One must also immerse oneself into the cognitive and affective layers that are directly or indirectly appropriate to the role (Berger and Luckmann 1991, 94). In the example of the friend above, it is not merely enough to know that one should help a friend with a flat tyre, but also to be sympathetically moved by their plight (to be sympathetically disposed) - to such an extent that one becomes readily willing to sacrifice one's own time and/or pressing needs in order to aid one's friend. According to Hardimon, the more we immerse ourselves in a role, the more we recognise and accept certain conditions as reasons to act one way instead of another (Hardimon 1994, 358) and the more our dispositions are shaped to conform to the role – ultimately becoming fixed over time.

An understanding of how roles can aid us in predicting future actions similarly enables us to evaluate past actions. According to Pettigrove, the role someone occupies gives us clues as to the motivational structure behind their actions (Pettigrove 2020, 21). Sentences such as: "Of course she ran to aid the man with chest pain in the restaurant, she is a doctor…" or "She loves to argue a point, she is a lawyer…" explains how our character and our roles are not only intertwined but assist us in understanding our past actions.

This relationship between roles and character is further evidenced when we evaluate each other. Imagine you meet a young man at a bar late on a weeknight, he appears fun loving and wholly care-free. He has had a few too many drinks and let's slip that his job in the private sector has made him incredibly rich because he has a monopoly on the product he sells in the town and thus overprices for it. Nearby, someone begins to choke on a peanut. For a few seconds everyone stares in bewilderment until finally the barman comes around and assists the person with the Heimlich manoeuvre. Relieved, you return to the young man. You have decided that you like his care-free attitude to life and his robust entrepreneurial spirit. You ask him what he does for a living, expecting him to say he is a businessman, and he replies that he is a neurosurgeon. Shocked, you quickly learn that he has a full slate of delicate surgeries scheduled for the next day, one of which is your own mother who had to withdraw her valuable savings in order to afford the surgery. Learning someone's role changes the way we evaluate someone's character. Similarly, a man who owns a few hectares of overgrown land on which he allows wild animals to roam freely is doing nothing wrong. In fact, it might be a mark in his favour that he is allowing mother nature to be left untamed by the self-centred ambition of man. It is a completely different story however, if we learn that this man is a farmer. As Philippa Foot states: "…a farmer is a good farmer only if he looks after his soil, his animals or his crops (Foot

1994, 208).” The combinations of actions and motivations that we find in individuals may be virtuous or vicious thus, depending on the role one occupies.

The relationship between roles and the fourth function of character, to describe who someone is, is clear. When asked who someone is, we naturally refer to their roles (Pettigrove 2020, 22). She is a lawyer, he is a farmer, she is a mother, he is a doctor, are generally the answers we give when describing someone. When we meet someone new and they ask us who we are, we generally reply by referring firstly to our roles. We do this because introducing someone, or ourselves, by referring to their/our roles, offers substantial information regarding the identity of the person or ourselves. Referring to roles in describing someone, enables us to predict the character of the person who is being referred to. By self-identifying with a certain role, especially one that is considered normatively-thick, we not only embrace the social identity of the role, but we also provide clues as to how we conceive of ourselves – i.e. our moral character (Pettigrove 2020, 23).

> …in performing a role the individual must see to it that the impressions of him that are conveyed in the situation are compatible with role-appropriated personal qualities effectively imputed to him: a judge is supposed to be deliberate and sober; a pilot, in a cockpit, to be cool; a book-keeper to be accurate and neat in doing his work. These personal qualities, effectively imputed and effectively claimed, combine with a position’s title, when there is one, to provide a basis of self-image for the incumbent and a basis for the image that his role others will have of him (Goffman 1972, 77).

I have shown that there is good reason to believe that roles and character are intertwined and that to the extent that we identify with certain roles, it moulds our character. This is by no means an uncontroversial topic in contemporary society, but it is not within the scope of this thesis to delve too deep into that quagmire.

I have attempted thus far to show that the medical profession is a moral community and that its members occupy a role, with its own role-specific morality. I have further attempted to show that there is a relationship between one’s role and one’s character. A character-based moral theory – which is generally referred to as virtue theory in philosophy - would thus be a good starting point to developing a comprehensive normative framework to undergird medical professionalism. To this end, Edmund Pellegrino clarifies what would be required of such a theory:

> At a minimum, any normative theory of the ethics of the healing relationship based in virtue will require the following: (1) a theory of medicine to define the telos, the good of medicine as an activity; (2) a definition of virtue in terms of that theory; and (3) a set of virtues entailed by the theory to characterize the "good" health professional (Pellegrino 1995, 266-267)

The *telos* of Medicine

The Greek Philosopher Aristotle, introducing his influential moral theory in the *Nicomachean Ethics* states that: "Every art and every enquiry, and similarly every action as well as choice, is held to aim at some good (Aristotle 2011, 1)."

For Aristotle, the aim of man (the *telos*), the greatest good, is happiness (*eudaimonia*). Although there is no proper English equivalent for the word *eudaimonia* (the words happiness or flourishing is used most often), it is not to be confused with the Benthamite concept of pleasure in Utilitarianism. Eudaimonia is to be understood as an internal good, the greatest good, that is chosen for its own sake and not for the sake of anything else.

> Happiness above all seems to be of this character, for we always choose it on account of itself and never on account of something else. Yet honour, pleasure, intellect, and every virtue we choose on their own account - for even if nothing resulted from them, we would choose each of them - but we choose them also for the sake of happiness, because we suppose that, through them, we will be happy. But nobody chooses happiness for the sake of these things, or, more generally, on account of anything else (Aristotle 2011, 11).

For Aristotle, this *telos* or aim of mankind – which he calls *eudaimonia* – is realised through the habituation of the virtues. In Greek, the word for virtue is *aretè*, which means "able to fulfil its natural task". For Aristotle thus, a good human life, a life of *eudaimonia*, consists in realising one's natural function – where the natural function is the sum-total of the virtues (Becker 2004, 269). Stated another way, the virtues are the means to an end, where the end of mankind (the *telos*) is *eudaimonia*. As Alasdair Macintyre points out in *After Virtue* however, although the relationship between the *telos* and the virtues is internal – the end cannot be characterised independently of a characterisation of the means – the virtues are secondary to the *telos*

(Macintyre 2007, 215). In order to conceptualise the virtues thus, one must first conceptualise the *telos*.

For Aristotle, and for other virtue theorists such as Thomas Aquinas, the *telos* of man was an uncontroversial subject. It was a given.

> Both the Classical and the Medieval Christian conceptions of virtue were based on a clear moral epistemology and metaphysics. They were rooted in the conviction that there existed an objective moral order and a philosophy of human nature ascertainable by human reason, which, in turn, defined the telos for human activity (Pellegrino 1995, 258)

Whereas for Aquinas, the *telos* was supernatural – union with God – for Aristotle it was a natural given. As Macintyre elucidates however, Aristotle's philosophy of human nature, and thus the *telos*, can only be understood within the concept of the *polis*, or community. There is no understanding of the *telos* being independent of the community – achieving the common good is a shared project between all who reside within the community (Macintyre 2007, 203). For this reason, as will be shown later, it is possible to formulate a common *telos* for medicine since medicine is a moral community with a universally shared tradition of moral values. It is for this reason also (this self-in-community conception) that African and Far Eastern ethics are considered forms of teleological ethics or virtue ethics.

Conversely, finding a consensus on the *telos* of mankind in general is an arduous task in contemporary society. Pellegrino is sceptical that any such universal agreement on the good or the *telos* of man is possible – especially given the modern liberal emphasis on the individual in the West (in contrast to African and Far Eastern cultures), the almost complete rejection of a community with shared moral values, the rejection of moral traditions and the emphasis on moral pluralism (Pellegrino 1995, 261, 266).

This is perhaps not the case with medicine where there is good reason to believe that a *telos* (a goal or end) of medicine can be formulated which would have near universal appeal. Oakley and Cocking, in their attempt to circumscribe the goal of medicine, argue that medicine must be seen as a key human good since it enables human beings to live a life of *eudaimonia* (Oakley and Cocking 2001, 74). I would argue that this is the case irrespective of one's subjective perception of what a flourishing life may be. Medicine remains a key human good, one integral

to conceptualising a good life, even if no-one could agree what a life of *eudaimonia* should look like.

Aristotle seemed to agree that the art of medicine was a distinct human good and defined its *telos*, its end, as serving health (Aristotle 2011, 2). As Oakley and Cocking emphasise however, there has been longstanding controversy over how to define the concept of health (Oakley and Cocking 2001, 75). I agree with their rejection of the idea that health merely entails the absence of disease. Not only does this conceptualise health merely in negative terms, but it is a far too narrow conception of what the practice of medicine entails – it also runs counter to the historical tradition of medicine. In an era where people live longer than they ever have in humankind's history and the increasing incidence of chronic disease, chronic pain states and patients living with multiple morbidities, the mere absence of disease as the definition of health falls short. Conversely, defining health (as the World Health Organisation do) in a positive yet overly broad sense as: "a state of complete mental, physical and social well-being (WHO 2020)" also misses the mark as it provides medical professionals with an exceedingly broad mandate – one that would seem to entail medical professionals carrying a degree of responsibility for almost the entirety of mankind's moral considerations (Ramsey 1970, 123).

To this end, Oakley and Cocking argue that the aim of medicine is to serve health: where health is defined as the normal biological and psychological functioning on a level typical for human beings (Oakley and Cocking 2001, 76). They take this understanding of normal human functioning to not only include the absence of disease but also the rejection of enhanced human functioning. Furthermore, their conceptualisation of serving health would include palliative care, or care of patients with chronic incurable diseases as they see this as attempts to serve health – to move towards health - even if normal functioning can never be achieved. Pellegrino and Thomasma advance a similar conceptualisation of the ends of medicine in their book *The Virtues of Medical Practice*: "…the ends of medicine are ultimately the restoration or improvement of health and, more proximately, to heal, that is, to cure illness and disease or, when this is not possible, to care for and help the patient to live with residual pain, discomfort, or disability (Pellegrino and Thomasma 1993, 52-53)*."*

It is not the purpose of this thesis to discuss the concept of health extensively, although these two definitions appear uncontroversial. With the explosion of modern medical advancement however, there is a need to examine the scope of what is understood by the second part of Pellegrino and Thomasma's conceptualisation of the ends of medicine – which is alluded to by

Oakley and Cocking. We live in an age where: (a) people already live longer than ever before, (b) people are able to live with a number of co-morbid diseases that are often accompanied with severe debilitation and/or severe pain, and (c) the technology exists to prolong life almost indefinitely, even in permanently comatose states – futurists believe that biological immortality may be possible by the year 2050 (Keach 2020). This has increasingly led to reflections on the nature of living and dying, what it means to live a good life and whether an individual has a "right to die". This topic is too broad to discuss here, but it has raised further questions regarding whether the aim of medicine includes prolonging life as long as possible. Neither Oakley and Cocking nor Pellegrino and Thomasma venture to elaborate on this, although their definitions could be understood to advocate for prolonging life and precluding radical concepts such as physician-assisted suicide.

I would argue that a better understanding of the ends of medicine is not to serve health necessarily but is, instead, to heal – which not only means to make sound or whole again, but also to alleviate (Lexico 2020). Thus, I would define the ends of medicine as, firstly, the alleviation of physical and psychological suffering and, secondly, to advance health (where possible) – where health is understood as curing disease and restoring normal biological and psychological human functioning.

As Pellegrino and Thomasma point out, this end of medicine – which I define in terms of healing – is not for the medical professional's good, but for the good of the patient (Pellegrino and Thomasma 1993, 53). This good is more than mere objective medical good – in which case the only ideal necessary would be competence - it also comprises the patients psychological, social and spiritual good, including the patient's own perception of good, i.e. what do they believe is in their interest; what do they consider to be for their own good? The ends of medicine – to heal – is thus synonymous with the good of the patient, so that the good (or virtuous) medical professional is one that acts for the good of the patient within the context of the healing relationship. The importance of the latter part is crucial since, as Oakley and Cocking elucidate clearly, this is not to be understood as a medical professional merely "serving patient autonomy" (Oakley and Cocking 2001, 81). A doctor who has sexual relations with his or her patient, even if the patient voluntarily consents to it and believes it to be in their own interest, betrays the healing relationship, and thus the *telos* of medicine, because the doctor has placed his or her own sexual gratification above the good of the patient. Similarly, a medical professional who acquiesces to the demand of a patient to provide him with anabolic steroids in order to look more muscular, betrays the healing relationship by contravening the *telos* of

medicine – it does not alleviate but causes suffering in the long-term and it does not advance health (biological and psychosocial) but worsens it. Another example may be the person who visits the medical professional for social reasons, perhaps to complain about a neighbour's dog who is incessantly ruining the garden. This would not be within the ambit of the role of the medical professional since this person is not suffering psychophysically and in need of alleviation or requiring restoration from any illness. If, however, the complaint is but a small part of a far larger problem – the patient is suffering from a major depressive episode causing debilitating psychological suffering and she doesn't know how to express it any other way – then it would be expected of the good medical professional to help such a patient.

In order to understand the relationship between the ends of medicine and the idea of the virtuous medical professional fully, I now turn to defining virtue.

Defining Virtue in Medicine

I have already stated that the virtues are the means to the end. Within medicine, the virtues are thus the means towards realising medicine's *telos*. Alasdair Macintyre, in *After Virtue*, maps out the evolution of the concept of virtue from heroic society to Aristotle to the New Testament all the way to modernity. It is pertinent to briefly discuss the virtues as understood in heroic society since they are one of, if not the original, architects of moral virtues – at least in narrative - and are integral to a proper understanding of any comprehensive theory of virtue. In heroic society, such as those found in the Homeric epics and the Icelandic and Celtic sagas, one's station in life – the social role one held – determined the virtues or character traits that one was expected to embody. The modern concept of the individual who is able to detach himself from his community and his given role, station or viewpoint did not exist in heroic society, as it still doesn't exist in, for example, traditional African society which make up the overwhelming majority of the population in Southern Africa (Mkhize 2014, 46) – there is good reason to think that such detachment is ontologically impossible because it is our very historicity, our prejudices or prejudgements in the words of Gadamer (Gadamer 1979, 9), that constitute our very being (Bernstein 1982, 827).

The values of the society were thus predetermined and thus also was a man's place with all the privileges and duties that followed from his station (Finley 2002, 114). Yet it was not just that each station had a prescribed set of duties and privileges, but also the actions that were required to be performed. Everything that a man (or woman) was, was tied up in his/her actions so that

to judge a man (or woman) was to judge his/her actions in light of the role or station he/she occupied (Macintyre 2007, 142). The virtues could thus not be divorced from the social structure. As Macintyre states: "…morality and social structure are in fact one and the same in heroic society (Macintyre 2007, 144)." A warrior who was not courageous, and acted courageously, was not a warrior – not in the sense that he was something else then, but that he could not exist.

> Identity in heroic society involves particularity and accountability. I am answerable for doing or failing to do what anyone who occupies my role owes to others and this accountability terminates only with death. I have until death to do what I have to do (Macintyre 2007, 147).

It is important to understand also that the Homeric epics and the sagas of Iceland and Ireland are narratives. The societies and characters they portray did not necessarily exist – except in the mind of their authors. Yet, the moral narrative is undoubtedly one born from a moral tradition that had survived multiple generations. To this end, although the moral structure of heroic societies seems strange to our modern sensibilities there is still something of value for us to take note of at this stage.

> …what we have to learn from heroic societies is twofold: first that all morality is always to some degree tied to the socially local and particular and that the aspirations of the morality of modernity to a universality freed from all particularity is an illusion; and secondly that there is no way to possess the virtues except as part of a tradition in which we inherit them and our understanding of them from a series of predecessors in which series heroic societies hold first place (Macintyre 2007, 147).

Despite modern attempts to refute the above, I would argue that it is in large part true even today. The historian Tom Holland, in his bestselling book *Dominion*, shows comprehensively how our secular, Western, moral edifice is built almost entirely on the Christian tradition so that almost every instinct and intuition we have, irrespective of our modern disregard for religion and purported belief in secular humanistic ideologies, is decidedly Christian (Holland 2019). It will become apparent later why giving a brief account of the virtues in heroic society was necessary for a complete understanding of a comprehensive virtue ethics account for medical professionalism. I will also address the charge that could be made, that this is a case of moral relativism.

The idea that the virtues are the means to a given end originated with Aristotle. For Aristotle a virtue is an excellent trait of character, or an excellent disposition which is habituated in a person by partaking in a certain human activity (Aristotle 2011, 26). It is thus not merely a feeling or emotion – although it includes this - but a rational, albeit complex, disposition which is entrenched in a person through habituation (Roberts 1989, 293). Macintyre calls this specific activity, this process in which the virtues are habituated, a 'practice' and defines it as:

> "…any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended (Macintyre 2007, 218)."

To illustrate the concept of a 'practice' and the difference between internal and external goods Macintyre uses the example of teaching a child, who loves sweets, to play chess (Macintyre 2007, 219). As motivation to play, the teacher offers a handful of sweets as reward every time the child plays a game, plus an extra handful of sweets every time the child wins. The child loves sweets and, thus motivated to get her hands on the bonus sweets, plays to win. The problem is that if the child is merely motivated to play chess to get sweets, there is little reason for the child not to cheat in order to win – and every reason to do so. Yet, it is hoped, that in time, as the child partakes in the activity of playing chess more regularly, her motivation for playing chess will shift to the extent that she will find that achieving those goods particular to chess such as: analytical skill, competitive intensity and strategic imagination: are a more rewarding reason for playing chess. If she then cheats, she would not only be defeating her opponent but also herself – as the goods internal to chess cannot be achieved by not playing according to the values or rules of chess. In the illustration above, it can be seen that by playing chess there are two goods which can be realised, external and internal goods. It is defined as external goods (in the example it is sweets, in real-life it may be money, prestige, power, etcetera) since it is not a good specifically tied to the practice but can be attained through a many number of different ways. It is also a good that is usually owned by the achiever and which can usually be measured and quantified in some manner. In contrast, internal goods are usually tied up to the specific practice so that it can only be attained by partaking in that specific

practice or a similar activity. The practice of medicine also consists in internal and external goods where the external goods are goods such as money (remuneration) and prestige. The internal goods, however, are tied up in the *telos* of medicine as described above (healing), manifested within the physician-patient relationship. It is only by the habituation and exercise of the virtues, that the goods internal to a practice, and thus its end or *telos*, can be realised.

For Aristotle these virtues are an integral part of doing right action since it is only the virtuous person who can be relied on to choose the right action reliably. Since for Aristotle there are no fixed or universalizable rules for conduct, it is only by reflecting on the meaning of moral phenomena that we can develop normative orientations (Becker 2004, 270) – I will have more to say on this (*phronesis*) at the end of the chapter. Macintyre, in attempting to illustrate Aristotle's point on right action, writes that it is possible for a soldier to perform the action that courage would have demanded, not because he is courageous, but because he is well-trained or because he fears his officers more than the enemy (Macintyre 2007, 175). The latter, however, is not reliable as moral motivation, and it is rather through the cultivation and perfection of the virtue of courage that a soldier would act courageously every time. Drawing on this, as well as Macintyre's conceptualisation of a practice, Pellegrino defines virtue as: "…a trait of character that disposes its possessor habitually to excellence of intent and performance with respect to the telos specific to a human activity (Pellegrino 1995, 268)." For his part, Macintyre defines virtue as: "…an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods (Macintyre 2007, 222).

Although the end, the *telos*, is primary in defining the virtues for a specific human activity, this only provides a partial definition of what a virtue is. Not all character traits are virtues, some are vices – and it is not inconceivable that a vice may also, in some measure, be a means to the same end as those to which the virtues aim. An example in medicine would be the overly compassionate doctor whose actions towards a patient the doctor has been treating for some time would come across not as compassionate anymore but as pity – where the sorrow the doctor feels has an element of condescension towards the patient (Oakley and Cocking 2001, 93). Another might be the doctor who lies to his/her patient about test results that would not have a significant impact on the health and healing relationship (such as a patient in end-stage renal failure from HIV, with days to live, who has an incidental finding of early primary osteosarcoma of his/her femur).

Aristotle recognised that character traits are present in differing degrees, some in deficiency, some in excess, some in the middle. For Aristotle, the virtues are precisely those traits that lie in the mean between two extremes – where the extremes are termed vices.

> Virtue is concerned with passions and actions, in which the excess is in error and the deficiency is blamed but the middle term is praised and guides one correctly, and both belong to virtue. Virtue, therefore, is a certain mean, since it, at any rate, is skillful in aiming at the middle term…On account of these considerations, then, to vice belongs the excess and the deficiency, to virtue the mean (Aristotle 2011, 34-35).

The virtues in medicine are thus the sum of excellent traits of character which provide the means to serving the ends of medicine, but which are also found to be in the middle of the two extremes of excess and deficiency. This serves as a strong base for developing a comprehensive normative virtue theory for medical professionalism (where medical professionalism is the disposition and conduct of a medical professional), although I would argue that it still lacks two key components. The first has been alluded to earlier in the chapter regarding the moral grounding of roles and their role-generated responsibilities or values. I showed the capriciousness of these values – subject to the preferences of anyone - if they are not morally justified. My virtue theory for medical professionalism provides this moral justification, although on its own it is arguably still vulnerable to the capriciousness that plagues postmodern society. What happens if one decides to change the ends of medicine as Applebaum proposes (Appelbaum 1999, 45-60)? Oakley and Cocking are sceptical that this is as easily conceived as stated though – it would have to be shown to be an internal good that leads to human flourishing, but it would also extinguish roles or professions as a concept entirely (Oakley and Cocking 2001, 89). To call oneself a medical professional then would mean nothing, since neither the word professional nor medical would consequently mean anything – it would be entirely subjective. As Ludwig Wittgenstein has shown however, words are not subjective – there is no "private language" - but are essentially social, getting their meaning from a community of language users (Wittgenstein 1986). To this end, Macintyre, in his book *After Virtue*, concludes that any theory of virtue must be sustained by and within a tradition. I will discuss this in greater detail below.

The second key element to a comprehensive normative virtue theory for medicine is an explication of *phronesis*. Aristotle believed that moral knowledge was not theoretical but

practical, and that *phronesis* – often translated as practical wisdom or prudence – was the central virtue without which none of the other virtues were intelligible (Aristotle 2011, 133).

> In the sense of phronesis, it is a knowledge that enables us to act in many practical situations encountered in everyday life. Phronesis is not simply knowing what good is, what virtue is and what the rules that govern our behaviour are. More importantly, it is knowing how to act in the practical situations of everyday life (van Niekerk and Nortjé 2013, 30)...

Phronesis is thus the central virtue which one necessarily requires, not only in order to know what the virtues are to a specific end – including an understanding of the mean between excess and deficiency – but also how to act in a given situation. Hans-Georg Gadamer described phronesis as the mediator between theoretical knowledge and practical knowledge – a form of reasoning, yielding a sort of ethical know-how, in which what is 'universal' (theory) is applied to the 'particular' (practical situation) (Gadamer 1979, 140). Although phronesis is a virtue, Aristotle characterised it as an intellectual virtue – in contrast to the moral virtues I have been discussing thus far.

> Virtue, then, is twofold, intellectual and moral. Both the coming-into-being and increase of intellectual virtue result mostly from teaching hence it requires experience and time-whereas moral virtue is the result of habit (Aristotle 2011, 26).

For Aristotle, the intellectual virtues, such as phronesis, are acquired through moral education, usually taking the form of learning from moral exemplars. It cannot be acquired or exercised through rule-following. Macintyre maintains however, that habituation of the virtues must precede this education, so that only those who have acquired good habits are able to theorise well about practical issues (Macintyre 2006, 3-4). John McDowell equates virtues with knowledge and asserts that knowledge implies that the person possessing it gets things right. Using the example of the virtue of kindness to explain the role that the virtues play in practical reasoning (*phronesis*), he argues that someone possessing the virtue of kindness can be relied on to act kindly in situations that demand kindness because the person is 'reliably sensitive' to the requirements of kindness in particular practical situations (McDowell 1979, 331). McDowell refers to the 'perceptual capacity' that those who possess the virtues have which enables them to recognise, in a given situation, according to which virtue to behave (Renani 2017, 67-68). In terms of its application to medicine: no two patients are the same and thus a

medical professional requires *phronesis* to know how to act benevolently toward his/her diverse range of patients. Benevolence might require stern words toward a patient defaulting on his diabetic treatment who now presents with early nephropathy, whilst this would be inappropriate toward a young child with a broken arm who climbed a tree in his or her backyard.

> It is sometimes complained that Aristotle does not attempt to outline a decision procedure for questions about how to behave. But we have good reason to be suspicious of the assumption that there must be something to be found along the route he does not follow (McDowell 1979, 347-348).

Virtue ethics and the concept of *phronesis* I have briefly outlined appears alien to our modern view of morality – which is largely deontological in that it comprises of rules and *a priori* principles. This topic is beyond the scope of this thesis, but as I will elucidate later in the chapter in the discussion of traditions and moral relativism, there is sufficient reason to think that true *a priori* principles do not exist. Macintyre certainly argues that even Kant's maxims, although presented as the products of a universal practical rationality (*a priori*), are little more than traditional values presented as being rationally right. Macintyre writes that: "Kant is not in any doubt as to which maxims are in fact the expression of the moral law…(because)…Kant never doubted for a moment that the maxims which he had learned from his own virtuous parents were those which had to be vindicated by a rational test (Macintyre 2007, 52)."

Phronesis is thus integral to virtue ethics, but it can only be acquired through education by those already possessing the moral virtues. As John McDowell states, this is because a conception of right action is grasped from the inside out (*a posteriori*) (McDowell 1979, 331). There are thus no rules or *a priori* moral principles to provide action-guidance – and there is good reason to believe that not only do *a priori* moral principles not actually exist, but that the moral life is far too complex to be reduced to following a sequence of rules and procedures (since cases inevitably appear in which the consequences of a mechanical application of the rules strike one as profoundly wrong (McDowell 1979, 336)). I will discuss *phronesis*, and how it relates to traditions (and thus action-guidance) in the last part of the chapter in order to provide my theory of virtue in medical professionalism with normative force.

The Virtues in Medicine

I have argued for the telos of medicine, and I have defined what virtue is. Furthermore, I have explicated in brief how the virtue of *phronesis* is central to any normative account of virtue – I will give this greater substance in the last section of the chapter. What follows are the virtues or character dispositions that are fundamental to medical professionalism.

Benevolence: Edmund Pellegrino calls this virtue the *sine qua non* of medicine since all patients wish to be helped and not harmed (Pellegrino 1995, 269). The virtue of benevolence disposes the medical professional to seek the good of the patient by focussing on the patients physical and psychological needs. In addition, the virtue of benevolence allows the medical professional to distinguish which treatment options are necessary and which would be excessive.

Compassion: The virtue of compassion is essential to medical professionalism since it provides a heightened awareness, a concern for, and an appreciation of the patients' plight, distinct needs and dependent state. Furthermore, compassion assures patients that they are regarded and valued as fellow human beings despite their compromised and fragile condition (Oakley and Cocking 2001, 93).

Altruism: The virtue of altruism is for many the essence of medical professionalism since it is the patient's interest and not self-interest that is foundational to the patient-physician relationship (ABIM 1995, 5). Altruism ensures that the patient would not be exploited for external means such as profit and would ensure that patients in dire need are not turned away if they cannot afford the medical professionals services. Furthermore, the virtue of altruism – a degree of self-sacrifice on the part of the medical professional – is often the only bulwark against leaving vulnerable patients at the mercy of a failed healthcare system or in situations such as war. The altruism shown by many medical professionals working day-in and day-out in the war-torn city of Aleppo during the Syrian war – as can be seen in the documentary *For Sama* (Al-Kateab, Al-Khateab and Al-Khateab 2019) – is an example of this moral excellence. Included here would be the medical professionals working during the Covid-19 crisis. The virtue of *courage* would be practiced in conjunction with the virtue of altruism in these cases.

Respect for persons: Thomas Aquinas called the virtue of respect or acknowledgment of the dignity of others *observantia* (Aquinas 1920). He deemed it a moral excellence to show respect or esteem for the dignity of others in all acts. This is an especially important virtue within the healthcare setting where the patient's dignity is restricted by ill health and dependence on

others for care (Jones 2015, 87). This virtue is analogous, although not synonymous with, Beauchamp and Childress' principle of respect for autonomy. It is usually practiced in conjunction with the virtue of compassion and prevents acts of overt medical paternalism taking place within the clinical encounter.

Trustworthiness: The virtue of trustworthiness is fundamental to the patient-physician relationship. It makes patients feel comfortable about making full, frank and timely disclosures of the sort of intimate information required to make a diagnosis and to effect healing (Oakley and Cocking 2001, 93). Keeping such information confidential then is also part of the virtue of trustworthiness.

Truthfulness: It is vital for a medical professional to give accurate and adequate information to a patient regarding his/her condition. Not only is this part of respecting the dignity of the person but it has been shown that this disposition improves patients' health (Ross and Nisbett 2011, 268). Related to truthfulness is the virtue of *honesty* or *humility*. It is a virtue of healing to admit ignorance when a medical professional does not know something – instead of lying – or when a medical professional has made a mistake. Furthermore, it is important to concede when efforts at diagnosis or treatment has failed, instead of subjecting the patient to further unnecessary tests (Oakley and Cocking 2001, 93)

Justice: A disposition to justice is essential in the practice of the virtuous medical professional in order that morally irrelevant grounds do not determine who receives care (Oakley and Cocking 2001, 93). The virtue of justice would thus dispose medical professionals to treating enemy combatants in a warzone for example, or illegal immigrants. Furthermore, according to Pellegrino, commutative justice is implicit throughout the healing relationship – which dictates that what is owed to each is given to each and equals are treated equally (Pellegrino 1995, 270).

Competence: Per-Erik Ellström, distinguishing between the mere holding of qualifications and actual competence, defines competence as: *"The potential capacity of an individual to successfully handle a certain situation or to complete a certain task* (Ellström 1997, 267)." Using this definition, Macaulay and Lawton believe that competence can be understood as a virtue, especially if the word *moral* is placed in front of the word *situation* (Macaulay and Lawton 2006, 705). In terms of medicine, the virtue of competence would encompass sound clinical, practical and ethical knowledge in order to heal the patient.

There are certainly other virtues that could be touted that would serve the *telos* of medicine, but this list, including the virtue of prudence or *phronesis*, is satisfactory. As Edmund Pellegrino points out, it is possible to reduce this list even more, since many of the virtues are derivative of other more foundational virtues (Pellegrino 1995, 270).

Moral Traditions

According to Alasdair Macintyre, no intention, and subsequent action, is intelligible without an understanding of the social setting in which it takes place – where a setting is either an institution, a practice or a milieu of some other human kind (Macintyre 2007, 240). Furthermore, a central notion to a setting is that it consists of a history: "…a history within which the histories of individuals not only are, but have to be, situated, just because without the setting and its changes through time the history of the individual agent and his changes through time will be unintelligible (Macintyre 2007, 240)."

To paraphrase an example from *After Virtue*, one walks past a small holding in a rural town and finds a man busy with a shovel in the garden. One enquires what the man is doing. The reply could be anything from: "digging" to "gardening" to "pleasing my wife" to "healthful exercise" to "preparing for winter" to "maintaining the property". As Macintyre observes, all may simultaneously be true and yet without knowing which intention from the agent is primary – and which are mere indirect consequences – we will not be able to even begin to characterise his behaviour adequately (Macintyre 2007, 239). Yet, it is not only knowledge of the agent's intentions which are important, but we also need to understand the history behind the agent's intentions. Perhaps the man has been married for decades and his wife has ordered him to partake in a physical activity in order to lose weight and thus his actions has nothing directly to do with gardening at all. Or perhaps the small holding has been in the man's family for generations and he is maintaining the historical property as every man in his family has done for centuries. It is only by understanding the setting – such as the specific history of this man's marriage within the institution of marriage or the man's place within the history of the property – that one can adequately understand the man's actions. Furthermore, we would need to know the beliefs of the man. Would he, for example, still be digging in the garden if he believed that it wouldn't please his wife? Would he do it if he believed that it would please his wife but that he was not getting any meaningful exercise from the activity?

Even with such a simple example, it should be clear that a narrative history behind the man's intentions is required in order to characterise his behaviour intelligibly. The mere act of digging would tell us nothing about what the man is in fact doing. If his answer to the question of what he is doing was simply digging, for no reason whatsoever, we would find his actions strange indeed. An action thus cannot be adequately understood and judged without an understanding of intentions, beliefs and settings – which is all tied up within a historical narrative (Macintyre 2007, 241). To further illuminate the point of a setting, the man's reply that he is digging in the garden to please his wife seems to us to be an intelligible answer. This could only be since within the institution of marriage, at least in the cultural setting from which I am writing, this is considered normal (read stereotypical) behaviour for a husband to do – pleasing his wife by doing menial jobs around the house. If, however, he had answered that he is digging in the garden to please the new butcher in town, it would be an unintelligible answer – at the very least it will require more of an explanation including the history of the community in which this man lived where pleasing the butcher is deemed morally expected behaviour. Even if the man were to answer that he is doing it to please his friend, it would not immediately be intelligible without some further explanation.

> …in successfully identifying and understanding what someone is doing we always move towards placing a particular episode in the context of a set of narrative histories, histories both of the individuals concerned and of the settings in which they act and suffer…we render the actions of others intelligible because action itself has a basically historical character. It is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others (Macintyre 2007, 245).

Reflecting on the work of Macintyre, as well as Burrel and Hauerwas (Burrel and Hauerwas 1981), Hilde Lindeman Nelson states that: "It is the story of one's community – whether it be ancient Greece, medieval Paris, or eighteenth-century Edinburgh – that develops one's capacity to see things as reasonable, appropriate, valuable, and so on (Nelson 2004, 165)."

Macintyre calls this story of one's community – this collection of specific historical narratives – a tradition. It is clear to see how this not only provides normative force and moral justification for conduct (whether rational or not) but is also able to sustain moral values within a community independent of the individuals that form part of the community at any given time. Yet, this

does not mean that a moral tradition is a fixed entity which cannot evolve. New narratives which grow out of, and are built on, older narratives are essential to avoid an epistemological crisis – which happens when the older narratives are unable to solve members of that tradition's problems any longer (Macintyre 1988, 361). I will build on this concept at the end of the chapter.

It is undoubtedly true, despite modernity's attempts to reject moral traditions, that they saturate our moral lives. I have already alluded to the Judeo-Christian tradition, which is fixed, probably irrevocably, in the psyche of the Western mind. The debate on abortion is to a large extent the debate between two different communities (pro-life and pro-choice), each with their own historical narratives (traditions) which inform their beliefs – although it could be argued, ironically, that both are derived in some sense from the Christian tradition since radical individualism in the West has its roots in the Protestant Reformation and Luther's conception of *sola scriptura*. As Kirsten Luker writes: "Beliefs about the rightness or wrongness of abortion both represent and illuminate our most cherished beliefs about the world, about motherhood, and about what it means to be human. It should not surprise us that these views admit of very little compromise (Luker 1984, 10)."

Even contemporary Western culture draws, in the words of H. Tristram Engelhardt, Jr, on a moral tradition – the moral tradition which attempts to step outside the constraints of particular cultures, including Western culture itself, by giving reasons and arguments anyone should accept (Engelhardt 1986, 6).

This all does not, however, mitigate against the charge usually laid against an ethic founded in historical tradition or narrative that it is morally relativistic. There are a number of points to consider but, in order to address this charge, it is important to discuss the term relativism – as well as its direct opposite, absolutism. In his essay, *Relativism and Foundationalism: some distinctions and strategies*, Michael Krausz states:

> "Absolutism…holds that the truth or the truth value of a proposition is not tied to the contingent (historical) conditions of the assertion of truth or truth value. Relativism denies this, holding that some truths or truth values are tied to such contingent conditions. What the nature of this "tie" is, and for what sorts of cases it might obtain, depends upon more precise formulations (Krausz 1984, 395)."

Many critics charge that absolutism is unattainable and that the concept of the ideal or objective observer which is external to the real world does not exist. For Nelson Goodman this is because there is no 'world' accessible, independent of our symbol systems, which can function in our cognitive judgements (Goodman 1978, I,5) (Krausz 1984, 395). Furthermore, Krausz asserts that: "…we are never "prior to" communities. We find ourselves in them, at least in virtue of being involved in particular practices and more generally in virtue of our ability to use language and to manipulate symbol systems at all. Here we do not start in the beginning; we start in the middle (Krausz 1984, 402)." This does not mean, however – even if one were to accept some form of relativism - that one is forced to accept radical relativism. Krausz distinguishes between the concept of relativism and that of relativity:

> Relativism holds that truth, or its cognates, is relative to a conceptual framework of some sort…Relativity, on the other hand, holds that cultural entities are to be understood or made intelligible in the cultural settings in which they appear. Insofar as intentional settings change over historical time, our understanding of them changes over time. But this does not mean that the multiplicity of frameworks, at any particular time, necessitates the systematic equivocation of truth (Krausz 1984, 397).

I agree with Christopher Lutz that Macintyre's theory of virtue and traditions embraces relativity and not relativism (Lutz 2004, 67) – one can see this in Macintyre's discussion of the Sophists relativistic view of virtue (Macintyre 2007, 162). According to Lutz:

> …the judgment that a theory is true cannot be reduced to an appeal to evidence because we recognise evidence as convincing, and carry out our appeal to that evidence, according to standards of rationality. We ascribe truth to theories when they are supported by our experiences, but we interpret our experiences according to the presuppositions that form our rationality. So there is a real distinction between the ascription of truth or falsity to a proposition and the actual truth or falsity of that proposition, whether or not the actual truth or falsity of that proposition can be established conclusively (Lutz 2004, 67).

To further illustrate the point, the famous physicist Richard Feynman was once asked (in a now famous interview) to give a reason as to why two magnets attract or repel each other (Feynman 1983). Using the example of a woman who slipped on ice, hurt her hip and whose husband is phoning the hospital, he explained why phrasing the question using 'why' is wrong (the person

should instead have asked: how, or by what means do two magnets attract each other?). This is because one could always follow up any answer with another why question, into perpetuity. Why did the woman slip on the ice? *Because the ice is slippery*. Or: Why did the woman's husband phone the hospital? *Because she is hurt and might have broken her hip*. Feynman explains that although this would satisfy most people, this would not satisfy an extra-terrestrial who knew nothing about our world or its make-up. The alien may enquire: Why did the husband phone the hospital? *Because he is concerned about the woman's welfare.* Why is he concerned about her welfare since not all husbands are concerned about their wives' welfare? *Because he is a good husband.* Why is he a good husband whilst others are not? *Because he loves and cares for her.* Why does he love and care for her, etcetera? Conversely, the alien may enquire as to why the ice is slippery? *Because the pressure of a weight on the ice causes it to melt just enough to cause a liquid surface on which one slips.* But why on ice and not on other surfaces? *Because water expands when it freezes whilst other substances contract.* Why does water expand when it freezes whilst other substances contract, etcetera?

Feynman concludes that by asking why perpetually one will be forced, in the end, to admit that what we consider to be true, is true because we allow it to be true within a particular framework. For Macintyre, this framework, in a moral sense, constitutes the entirety of our history, stories and theories on a personal and a community level. This does not mean that we abandon all rationality, but merely that an appeal to objectivity from the view of an ideal observer is an illusion. This certainly does not necessitate that moral traditions are immune to moral criticism (a relativist would conclude this since there can be no moral conflict within or between rival traditions when all truth is relative), but that objective moral criticism cannot be justified by an appeal to an objective ideal observer. It can only, as Lutz explains, be founded upon the best theories, the nearest truth, so far developed in response to the experiences and epistemological crises of a person or a community who adheres to the experience of reality. The charge of moral relativism, as it pertains to moral traditions is thus unfounded.

Phronesis, Virtue Ethics and Traditions

I have argued that medicine embodies certain moral values (or norms) which have been part and parcel of medical practice since the dawn of time, spanning different cultures, different continents and different time-periods. As a collective these moral values have formed the foundation of a moral tradition which is shared implicitly by all members of the medical moral community – irrespective of whether this is explicitly accepted by the members or not since

one cannot detach oneself, in the words of Georg-Hans Gadamer, from one's 'prejudices' which inform ones very being (Gadamer 2008, 8). These values or norms are not to be understood as *a priori* principles however, but have been inherited from this moral tradition *a posteriori* as the tradition evolved from the very first moment someone entered into a healing relationship with another human being. In the written narrative, the Egyptian physician Imhotep and the Hippocratic physicians would be an example of early moral progenitors.

I have, however, not argued in chapter 3 for a narrative ethics account to undergird medical professionalism – I have merely charged that a moral tradition of medicine exists, is implicitly shared by the global moral community of medical professionals, and provides and has sustained its moral values or norms. Instead, I have proposed a virtue ethics approach to medical professionalism (i.e. medical practice) grounded in the Aristotelian tradition and informed predominantly by the work of Alasdair Macintyre and Edmund Pellegrino. Although there is significant convergence and co-dependency between the virtue theory I have explicated and the moral tradition of medicine they can still be argued to be, in certain respects, two distinct traditions. Both are equally indispensable to a comprehensive normative virtue account for medical professionalism however. To illustrate their co-dependency, the virtues of medicine I have expounded on, such as benevolence, compassion and altruism are contextually understood because we view them in light of the historical narrative of medicine. A moral tradition of medicine is also needed to provide a virtue ethics account of medical professionalism (in particular the virtue of *phronesis*) with its normative force (action-guidance). It is often the criticism that virtue ethics is not action guiding and that there is a circularity to its argument: "You can tell what is good by what good people do, and you can tell who the good people are as they are the ones doing good things (Misselbrook 2015, 54)." The concept of *phronesis* is asserted as being the means by which the virtuous person deliberates and reasons in order to justify or inform his/her moral judgements or *praxis* (the particular) (Bernstein 1982, 832) – especially in moral dilemmas. As Richard Bernstein explains however, justification for moral judgements or conduct requires some standards or norms on which to base such judgements or acts (Bernstein 1982, 839) – which cannot merely be attributed to the tradition within which one is situated (virtue ethics in this case). I argue that medicine's moral community, with its shared moral tradition, provides these standards or norms for a virtue ethics account of medical professionalism.

> …what is required for the exercise of phronesis, and what keeps it from degenerating into the mere cleverness of the deinos, is the existence of such a

> nomos in the polis or community. Given a community in which there is a living shared acceptance of ethical principles and norms, then phronesis as the mediation of such universals in concrete particular situations makes sense (Bernstein 1982, 840).

To rephrase virtue ethics' argument in medicine then: One can tell what is morally good/right in medical practice by what virtuous medical professionals do and one can tell who the virtuous medical professionals are because the virtues they habituate (through their 'practice') serve as the means toward the *telos* of medicine (healing), and their moral deliberations (through *phronesis*) can be justified by their rational conformation to the moral norms espoused by a moral community of medicine with a universally shared moral tradition.

Conclusion and Recommendations

> "No matter to what depths a society may fall, virtuous persons will always be beacons that light the way back to moral sensitivity; virtuous physicians are the beacons that show the way back to moral credibility for the whole profession (Pellegrino 1985, 252)"

Medical Professionalism in modern contemporary society, especially in the West, is in a state of crisis. The long history of medical professionalism – a moral tradition oblivious to cultural, ethnic and national boundaries – has been largely discarded as a relic of the past in the mind of many influential thinkers (mostly outside the profession itself). The medical profession is not blameless and has, to a considerable degree, allowed its soul to be sold – many professionals are even actively participating in it – to the ethos of the marketplace where the only good that matters is profit and efficiency. This deprofessionalisation has been exacerbated, ironically, by the rise of the bioethics movement and principlism – where the principle of respect for autonomy is given primacy above all else. Unfortunately, principlism merely describes the moral complexities of medical cases using the principlist framework whilst offering little to no action-guidance – it is left up to each individual to weigh up the principles for themselves. This normative vacuum – created by principlism trying to incorporate a host of broad-based moral theories that are fundamentally in conflict with each other – has led to a smorgasbord of rules, rights, duties, principles, virtues and values to try and define medical professionalism. Nowhere is this more evident than the Physician Charter on Medical Professionalism (ABIM Foundation 2002) – a charter that has been adopted by most countries around the globe. This perceived moral document – steeped in vapid platitudes – has left medical professionals and medical students at sea, vulnerable to the predatory instincts of those who seek to commodify medicine for commercial purposes. The medical profession has done little to combat this plunge into crisis, one of the main reasons being its inability to formulate a comprehensive, robust normative moral theory to undergird the profession – and by extension the medical professional's expected character and conduct (professionalism).

Some commentators – almost exclusively Western non-medical professionals – could not be more pleased with this state of adversity, believing that the elitism and paternalism they perceive the medical profession to embody is an existential threat to liberal democracy, human

rights and a just society. I believe their zeal to have everyone conform to a broad-based, universal and largely impartial morality, where roles and role-generated responsibilities are rejected, will cause irreparable harm to the fabric of society. Not only are these theories unable to appreciate what gives moral meaning to our lives in a general sense, but they cannot accommodate the intrinsic value we place on interpersonal relationships – the healing relationship between physician and patient being the foundation upon which the entire practice of medicine rests. It should come as no surprise thus that if the role of the medical professional cannot be cogently justified using impartial broad-based moral theories, that the entire edifice will eventually collapse. To this end there are only two options available; either society must continue in its fervent pursuit of a broad-based impartial morality to encompass all of our moral considerations and moral values, and accept the dire consequences it would have for medicine and ultimately society at large, or; the medical profession must be allowed to be a moral community and professionalism undergirded by a moral theory that not only justifies its distinct moral values but provides action-guiding force.

I argue that the medical profession is indeed valuable and that the role the professional plays in society is an intrinsic moral good, a good all human beings need to live a flourishing life. I believe the practice of medicine is not only a scientific endeavour but is also a moral enterprise. To this end, I have argued that a largely Aristotelian theory of virtue, sustained and given normative force by a medical tradition unrestricted by cultural, ethnic or national boundaries and stretching back millennia, undergirds and justifies the practice of medicine by medical professionals i.e. medical professionalism, even in the 21st century.

On a practical level, if adopted, this would have significant consequences to the manner in which medicine is taught and practiced moving forward. First, medical education would have to recognise the importance of moral exemplars (role-models) in medical education. Not only in order to reinforce and support the habituation of the virtues in undergraduates but specifically to teach the virtue of *phronesis*. A return to a master-apprentice form of medical education (from a moral point-of-view) must be considered whilst simultaneously accepting that constructing an ideal-observer type mechanism to objectively evaluate the entire scope of medical professionalism is a fruitless endeavour. Secondly, the importance of understanding the medical tradition within which one (as either a medical student or a practicing medical professional) is implicitly immersed, including its long narrative history, is an absolute necessity. The physician-philosophers of old intimately recognised the need for physicians to

be well-versed in the ‘classics’ and it seems the height of hubris that in the modern era we have concluded it to be unnecessary for medical students or medical practitioners to read anything beyond academic journals and scientific textbooks. Knowledge is also an absolute necessity for critical deliberation on the moral tradition (to enable it to evolve) and the practice of medicine in order to meet the existential crises that the profession will undoubtedly face in the years to come. Leaving it solely to those outside of the moral community to decide the profession’s fate, even if conducted with the most noble of intentions, does not bode well for the future of the art of medicine – an art encompassing both scientific and moral dimensions. On the current track, a complete commodification and commercialisation of medicine beckons, with the professional-patient relationship denigrated to a mere contractual agreement of morally minimalistic cold and indifferent duties and rules. As the world is gripped in the current Covid-19 pandemic, we as a global society can only be grateful that most medical professionals still do not define their practice according to the limited scope of the deontological principle of beneficence or to a utilitarian conception of altruism or to the single-minded pursuit of external goods. If anything, this once-in-a-lifetime pandemic has given the medical profession the opportunity to return to its roots.

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